Filing at a Glance

Company:	Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV
Product Name:	DC AHI SG HMO 2018
State:	District of Columbia
TOI:	HOrg02G Group Health Organizations - Health Maintenance (HMO)
Sub-TOI:	HOrg02G.004F Small Group Only - HMO
Filing Type:	Rate
Date Submitted:	05/01/2017
SERFF Tr Num:	AETN-131001834
SERFF Status:	Assigned
State Tr Num:	
State Status:	
Co Tr Num:	DCAHISG2018
Implementation Date Requested:	01/01/2018
Author(s):	Amy Ovuka, Maxwell Nurnberger, Diane Anderson, Erica Mitchell
Reviewer(s):	Efren Tanhehco (primary), John Morgan, Damon Siler, Dave Dillon
Disposition Date:	
Disposition Status:	
Implementation Date:	

State Filing Description:

State: *District of Columbia* **Filing Company:** *Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV*

TOI/Sub-TOI: *HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO*

Product Name: *DC AHI SG HMO 2018*

Project Name/Number: *2018 Exchange - Aetna/HMO*

General Information

Project Name: 2018 Exchange - Aetna
Project Number: HMO
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Employer
Filing Status Changed: 05/02/2017
State Status Changed:
Created By: Maxwell Nurnberger
Corresponding Filing Tracking Number:

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Small
Overall Rate Impact:

Deemer Date:
Submitted By: Diane Anderson

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Exchange Intentions: Includes forms for products to be offered to Small Groups on the DC Health Benefits Exchange.

Filing Description:

Aetna Health, Inc. 1Q18 Small Group HMO rate filing for DC.
The corresponding forms filing was submitted separately. The SERFF ID Number is AETN-130955797.

In addition, please note that the corresponding HIOS Submission ID is 73987-945776385555740674.

Company and Contact

Filing Contact Information

Diane Anderson,
151 Farmington Ave
Hartford, CT 06156

AndersonD1@aetna.com
860-273-3188 [Phone]

Filing Company Information

Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV
1425 Union Meeting Road
Blue Bell, PA 19422
(999) 999-9999 ext. [Phone]

CoCode: 95109
Group Code: 1
Group Name:
FEIN Number: 23-2169745

State of Domicile: Pennsylvania
Company Type:
State ID Number:

Filing Fees

Fee Required? No
Retaliatory? No
Fee Explanation:

SERFF Tracking #:	*AETN-131001834*	***State Tracking #:***		***Company Tracking #:***	*DCAHISG2018*

State:	*District of Columbia*	***Filing Company:***	*Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV*
TOI/Sub-TOI:	*HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO*		
Product Name:	*DC AHI SG HMO 2018*		
Project Name/Number:	*2018 Exchange - Aetna/HMO*		

Rate Information

Rate data applies to filing.

Filing Method:	Review & Approval
Rate Change Type:	Increase
Overall Percentage of Last Rate Revision:	9.100%
Effective Date of Last Rate Revision:	01/01/2017
Filing Method of Last Filing:	Review & Approval

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	Number of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV	Increase	9.380%	9.380%	$-207,964	131	$723,495	15.332%	8.413%

Rate Review Detail

COMPANY:

Company Name: Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV

HHS Issuer Id: 73987

PRODUCTS:

Product Name	HIOS Product ID	HIOS Submission ID	Number of Covered Lives
DC AHI SG HMO 2018	73987DC004	73987-945776385555740674	180

Trend Factors:

FORMS:

New Policy Forms: HI SG-SOB-14038682 02-HIX, HI SG-SOB-14038683 02-HIX, HI SG-SOB-14038684 02-HIX, HI SG-SOB-14038685 02-HIX, HI SG-SOB-14038686 02-HIX, HI SG-SOB-14038687 02-HIX, HI SG HCOC 2018 02-HIX, HI SG HGrpAg 03

Affected Forms:

Other Affected Forms:

REQUESTED RATE CHANGE INFORMATION:

Change Period: Quarterly

Member Months: 5,412

Benefit Change: None

Percent Change Requested: Min: 8.413 Max: 15.332 Avg: 9.38

PRIOR RATE:

Total Earned Premium: 931,459.00

Total Incurred Claims: 724,861.00

Annual $: Min: 294.91 Max: 483.69 Avg: 430.51

REQUESTED RATE:

Projected Earned Premium: 723,495.00

Projected Incurred Claims: 542,884.00

Annual $: Min: 328.53 Max: 517.51 Avg: 470.89

SERFF Tracking #: AETN-131001834 **State Tracking #:** **Company Tracking #:** DCAHISG2018

State: District of Columbia **Filing Company:** Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV

TOI/Sub-TOI: HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO

Product Name: DC AHI SG HMO 2018

Project Name/Number: 2018 Exchange - Aetna/HMO

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		DC AHI SG HMO 2018	HI SG-SOB-14038682 02-HIX, HI SG-SOB-14038683 02-HIX, HI SG-SOB-14038684 02-HIX, HI SG-SOB-14038685 02-HIX, HI SG-SOB-14038686 02-HIX, HI SG-SOB-14038687 02-HIX, HI SG HCOC 2018 02-HIX, HI SG HGrpAg 03	Revised	Previous State Filing Number: AETN-130533832 Percent Rate Change Request: 9.38	DC_SG_73987_Rates_ON_1Q2018_v1.pdf, DC_SG_73987_Rates_ON_2Q2018_v1.pdf, DC_SG_73987_Rates_ON_3Q2018_v1.pdf, DC_SG_73987_Rates_ON_4Q2018_v1.pdf, DC_SG_73987_Rates_ON_1Q2018_v1.xlsm,

SERFF Tracking #:	*AETN-131001834*	***State Tracking #:***		***Company Tracking #:***	*DCAHISG2018*

State:	*District of Columbia*	***Filing Company:***	*Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV*
TOI/Sub-TOI:	*HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO*		
Product Name:	*DC AHI SG HMO 2018*		
Project Name/Number:	*2018 Exchange - Aetna/HMO*		

Attachment DC_SG_73987_Rates_ON_1Q2018_v1.xlsm is not a PDF document and cannot be reproduced here.

2018 Rates Table Template v7.1	*All fields with an asterisk (*) are required. To validate press Validate button or Ctrl + Shift + I. To finalize, press Finalize button or Ctrl + Shift + F.*			
	If you are in a community rating state, select Family-Tier Rates under Rating Method and fill in all columns.			
	If you are not in a community rating state, select Age-Based Rates under Rating Method and provide an Individual Rate for every age band.			
	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.			
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + H. All plans must have the same dates on a sheet.			
HIOS Issuer ID*	73987			
Federal TIN*	23-2169745			
Rate Effective Date*	1/1/2018			
Rate Expiration Date*	3/31/2018			
Rating Method*	Age-Based Rates			

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Required:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan
73987DC0040017	Rating Area 1	No Preference	0-14	308.39
73987DC0040017	Rating Area 1	No Preference	15	308.39
73987DC0040017	Rating Area 1	No Preference	16	308.39
73987DC0040017	Rating Area 1	No Preference	17	308.39
73987DC0040017	Rating Area 1	No Preference	18	308.39
73987DC0040017	Rating Area 1	No Preference	19	308.39
73987DC0040017	Rating Area 1	No Preference	20	308.39
73987DC0040017	Rating Area 1	No Preference	21	342.81
73987DC0040017	Rating Area 1	No Preference	22	342.81
73987DC0040017	Rating Area 1	No Preference	23	342.81
73987DC0040017	Rating Area 1	No Preference	24	342.81
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73987DC0040017	Rating Area 1	No Preference	26	342.81
73987DC0040017	Rating Area 1	No Preference	27	342.81
73987DC0040017	Rating Area 1	No Preference	28	350.83
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73987DC0040017	Rating Area 1	No Preference	31	376.77
73987DC0040017	Rating Area 1	No Preference	32	385.25
73987DC0040017	Rating Area 1	No Preference	33	394.21
73987DC0040017	Rating Area 1	No Preference	34	403.64
73987DC0040017	Rating Area 1	No Preference	35	413.07
73987DC0040017	Rating Area 1	No Preference	36	422.51
73987DC0040017	Rating Area 1	No Preference	37	431.94
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73987DC0040017	Rating Area 1	No Preference	39	442.31
73987DC0040017	Rating Area 1	No Preference	40	459.76
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73987DC0040056	Rating Area 1	No Preference	51	457.38
73987DC0040056	Rating Area 1	No Preference	52	475.22
73987DC0040056	Rating Area 1	No Preference	53	493.68
73987DC0040056	Rating Area 1	No Preference	54	513.05
73987DC0040056	Rating Area 1	No Preference	55	533.05
73987DC0040056	Rating Area 1	No Preference	56	553.96
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73987DC0040056	Rating Area 1	No Preference	63	670.54
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73987DC0040057	Rating Area 1	No Preference	63	777.53
73987DC0040057	Rating Area 1	No Preference	64 and over	777.53

2018 Rates Table Template v7.1	*All fields with an asterisk (*) are required. To validate press Validate button or Ctrl + Shift + I. To finalize, press Finalize button or Ctrl + Shift + F.*			
	If you are in a community rating state, select Family-Tier Rates under Rating Method and fill in all columns.			
	If you are not in a community rating state, select Age-Based Rates under Rating Method and provide an Individual Rate for every age band.			
	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.			
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + H. All plans must have the same dates on a sheet.			
HIOS Issuer ID*	73987			
Federal TIN*	23-2169745			
Rate Effective Date*	4/1/2018			
Rate Expiration Date*	6/30/2018			
Rating Method*	Age-Based Rates			

Plan ID*	Rating Area ID*	Tobacco*	Age*	Individual Rate*
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Required:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan
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73987DC0040017	Rating Area 1	No Preference	16	316.49
73987DC0040017	Rating Area 1	No Preference	17	316.49
73987DC0040017	Rating Area 1	No Preference	18	316.49
73987DC0040017	Rating Area 1	No Preference	19	316.49
73987DC0040017	Rating Area 1	No Preference	20	316.49
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73987DC0040017	Rating Area 1	No Preference	31	386.67
73987DC0040017	Rating Area 1	No Preference	32	395.38
73987DC0040017	Rating Area 1	No Preference	33	404.57
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73987DC0040017	Rating Area 1	No Preference	35	423.93
73987DC0040017	Rating Area 1	No Preference	36	433.61
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73987DC0040056	Rating Area 1	No Preference	62	688.16

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73987DC0040056	Rating Area 1	No Preference	64 and over	688.16
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73987DC0040057	Rating Area 1	No Preference	51	544.30
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73987DC0040057	Rating Area 1	No Preference	55	634.34
73987DC0040057	Rating Area 1	No Preference	56	659.23
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73987DC0040057	Rating Area 1	No Preference	58	711.58
73987DC0040057	Rating Area 1	No Preference	59	739.40
73987DC0040057	Rating Area 1	No Preference	60	768.31
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73987DC0040057	Rating Area 1	No Preference	62	797.96
73987DC0040057	Rating Area 1	No Preference	63	797.96
73987DC0040057	Rating Area 1	No Preference	64 and over	797.96

2018 Rates Table Template v7.1	*All fields with an asterisk (*) are required. To validate press Validate button or Ctrl + Shift + I. To finalize, press Finalize button or Ctrl + Shift + F.*			
	If you are in a community rating state, select Family-Tier Rates under Rating Method and fill in all columns.			
	If you are not in a community rating state, select Age-Based Rates under Rating Method and provide an Individual Rate for every age band.			
	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.			
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + H. All plans must have the same dates on a sheet.			
HIOS Issuer ID*	73987			
Federal TIN*	23-2169745			
Rate Effective Date*	7/1/2018			
Rate Expiration Date*	9/30/2018			
Rating Method*	Age-Based Rates			

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Required:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan
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73987DC0040017	Rating Area 1	No Preference	18	324.81
73987DC0040017	Rating Area 1	No Preference	19	324.81
73987DC0040017	Rating Area 1	No Preference	20	324.81
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73987DC0040017	Rating Area 1	No Preference	22	361.07
73987DC0040017	Rating Area 1	No Preference	23	361.07
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73987DC0040017	Rating Area 1	No Preference	31	396.83
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73987DC0040017	Rating Area 1	No Preference	42	522.98
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73987DC0040017	Rating Area 1	No Preference	47	633.23
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73987DC0040017	Rating Area 1	No Preference	62	1082.70
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73987DC0040021	Rating Area 1	No Preference	49	702.71
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73987DC0040021	Rating Area 1	No Preference	53	819.06
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73987DC0040046	Rating Area 1	No Preference	47	632.52
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73987DC0040046	Rating Area 1	No Preference	55	859.73
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73987DC0040057	Rating Area 1	No Preference	23	273.10
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73987DC0040057	Rating Area 1	No Preference	47	478.96
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73987DC0040057	Rating Area 1	No Preference	57	702.85
73987DC0040057	Rating Area 1	No Preference	58	730.27
73987DC0040057	Rating Area 1	No Preference	59	758.82
73987DC0040057	Rating Area 1	No Preference	60	788.50
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73987DC0040057	Rating Area 1	No Preference	62	818.93
73987DC0040057	Rating Area 1	No Preference	63	818.93
73987DC0040057	Rating Area 1	No Preference	64 and over	818.93

2018 Rates Table Template v7.1	*All fields with an asterisk (*) are required. To validate press Validate button or Ctrl + Shift + I. To finalize, press Finalize button or Ctrl + Shift + F.*			
	If you are in a community rating state, select Family-Tier Rates under Rating Method and fill in all columns.			
	If you are not in a community rating state, select Age-Based Rates under Rating Method and provide an Individual Rate for every age band.			
	If Tobacco is Tobacco User/Non-Tobacco User, you must give a rate for Tobacco Use and Non-Tobacco Use.			
	To add a new sheet, press the Add Sheet button, or Ctrl + Shift + H. All plans must have the same dates on a sheet.			
HIOS Issuer ID*	73987			
Federal TIN*	23-2169745			
Rate Effective Date*	10/1/2018			
Rate Expiration Date*	12/31/2018			
Rating Method*	Age-Based Rates			

Plan ID*	**Rating Area ID***	**Tobacco***	**Age***	**Individual Rate***
Required: Enter the 14-character Plan ID	**Required:** Select the Rating Area ID	**Required:** Select if Tobacco use of subscriber is used to determine if a person is eligible for a rate from a plan	**Required:** Select the age of a subscriber eligible for the rate	**Required:** Enter the rate of an Individual Non-Tobacco or No Preference enrollee on a plan
73987DC0040017	Rating Area 1	No Preference	0-14	333.35
73987DC0040017	Rating Area 1	No Preference	15	333.35
73987DC0040017	Rating Area 1	No Preference	16	333.35
73987DC0040017	Rating Area 1	No Preference	17	333.35
73987DC0040017	Rating Area 1	No Preference	18	333.35
73987DC0040017	Rating Area 1	No Preference	19	333.35
73987DC0040017	Rating Area 1	No Preference	20	333.35
73987DC0040017	Rating Area 1	No Preference	21	370.55
73987DC0040017	Rating Area 1	No Preference	22	370.55
73987DC0040017	Rating Area 1	No Preference	23	370.55
73987DC0040017	Rating Area 1	No Preference	24	370.55
73987DC0040017	Rating Area 1	No Preference	25	370.55
73987DC0040017	Rating Area 1	No Preference	26	370.55
73987DC0040017	Rating Area 1	No Preference	27	370.55
73987DC0040017	Rating Area 1	No Preference	28	379.22
73987DC0040017	Rating Area 1	No Preference	29	387.37
73987DC0040017	Rating Area 1	No Preference	30	397.06
73987DC0040017	Rating Area 1	No Preference	31	407.25
73987DC0040017	Rating Area 1	No Preference	32	416.43
73987DC0040017	Rating Area 1	No Preference	33	426.11
73987DC0040017	Rating Area 1	No Preference	34	436.31
73987DC0040017	Rating Area 1	No Preference	35	446.50
73987DC0040017	Rating Area 1	No Preference	36	456.69
73987DC0040017	Rating Area 1	No Preference	37	466.89
73987DC0040017	Rating Area 1	No Preference	38	472.49
73987DC0040017	Rating Area 1	No Preference	39	478.10
73987DC0040017	Rating Area 1	No Preference	40	496.96
73987DC0040017	Rating Area 1	No Preference	41	516.33
73987DC0040017	Rating Area 1	No Preference	42	536.72
73987DC0040017	Rating Area 1	No Preference	43	557.62
73987DC0040017	Rating Area 1	No Preference	44	579.53
73987DC0040017	Rating Area 1	No Preference	45	601.96
73987DC0040017	Rating Area 1	No Preference	46	625.41
73987DC0040017	Rating Area 1	No Preference	47	649.87
73987DC0040017	Rating Area 1	No Preference	48	675.36
73987DC0040017	Rating Area 1	No Preference	49	701.86
73987DC0040017	Rating Area 1	No Preference	50	729.39
73987DC0040017	Rating Area 1	No Preference	51	757.93
73987DC0040017	Rating Area 1	No Preference	52	787.49
73987DC0040017	Rating Area 1	No Preference	53	818.07
73987DC0040017	Rating Area 1	No Preference	54	850.19
73987DC0040017	Rating Area 1	No Preference	55	883.32
73987DC0040017	Rating Area 1	No Preference	56	917.98
73987DC0040017	Rating Area 1	No Preference	57	953.65
73987DC0040017	Rating Area 1	No Preference	58	990.86
73987DC0040017	Rating Area 1	No Preference	59	1029.60
73987DC0040017	Rating Area 1	No Preference	60	1069.87
73987DC0040017	Rating Area 1	No Preference	61	1111.15
73987DC0040017	Rating Area 1	No Preference	62	1111.15
73987DC0040017	Rating Area 1	No Preference	63	1111.15
73987DC0040017	Rating Area 1	No Preference	64 and over	1111.15
73987DC0040021	Rating Area 1	No Preference	0-14	342.52
73987DC0040021	Rating Area 1	No Preference	15	342.52
73987DC0040021	Rating Area 1	No Preference	16	342.52
73987DC0040021	Rating Area 1	No Preference	17	342.52
73987DC0040021	Rating Area 1	No Preference	18	342.52
73987DC0040021	Rating Area 1	No Preference	19	342.52
73987DC0040021	Rating Area 1	No Preference	20	342.52
73987DC0040021	Rating Area 1	No Preference	21	380.75
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73987DC0040021	Rating Area 1	No Preference	23	380.75
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73987DC0040021	Rating Area 1	No Preference	27	380.75
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73987DC0040021	Rating Area 1	No Preference	29	398.03
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73987DC0040021	Rating Area 1	No Preference	31	418.46
73987DC0040021	Rating Area 1	No Preference	32	427.89
73987DC0040021	Rating Area 1	No Preference	33	437.84

73987DC0040021	Rating Area 1	No Preference	34	448.31
73987DC0040021	Rating Area 1	No Preference	35	458.79
73987DC0040021	Rating Area 1	No Preference	36	469.26
73987DC0040021	Rating Area 1	No Preference	37	479.74
73987DC0040021	Rating Area 1	No Preference	38	485.50
73987DC0040021	Rating Area 1	No Preference	39	491.26
73987DC0040021	Rating Area 1	No Preference	40	510.64
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73987DC0040021	Rating Area 1	No Preference	42	551.49
73987DC0040021	Rating Area 1	No Preference	43	572.96
73987DC0040021	Rating Area 1	No Preference	44	595.48
73987DC0040021	Rating Area 1	No Preference	45	618.53
73987DC0040021	Rating Area 1	No Preference	46	642.62
73987DC0040021	Rating Area 1	No Preference	47	667.76
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73987DC0040021	Rating Area 1	No Preference	51	778.79
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73987DC0040021	Rating Area 1	No Preference	55	907.62
73987DC0040021	Rating Area 1	No Preference	56	943.24
73987DC0040021	Rating Area 1	No Preference	57	979.90
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73987DC0040021	Rating Area 1	No Preference	59	1057.93
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73987DC0040021	Rating Area 1	No Preference	63	1141.73
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73987DC0040029	Rating Area 1	No Preference	0-14	274.17
73987DC0040029	Rating Area 1	No Preference	15	274.17
73987DC0040029	Rating Area 1	No Preference	16	274.17
73987DC0040029	Rating Area 1	No Preference	17	274.17
73987DC0040029	Rating Area 1	No Preference	18	274.17
73987DC0040029	Rating Area 1	No Preference	19	274.17
73987DC0040029	Rating Area 1	No Preference	20	274.17
73987DC0040029	Rating Area 1	No Preference	21	304.77
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73987DC0040029	Rating Area 1	No Preference	23	304.77
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73987DC0040029	Rating Area 1	No Preference	28	311.90
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73987DC0040029	Rating Area 1	No Preference	31	334.96
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73987DC0040029	Rating Area 1	No Preference	34	358.85
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73987DC0040029	Rating Area 1	No Preference	39	393.23
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73987DC0040029	Rating Area 1	No Preference	41	424.67
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73987DC0040029	Rating Area 1	No Preference	43	458.63
73987DC0040029	Rating Area 1	No Preference	44	476.65
73987DC0040029	Rating Area 1	No Preference	45	495.10
73987DC0040029	Rating Area 1	No Preference	46	514.38
73987DC0040029	Rating Area 1	No Preference	47	534.51
73987DC0040029	Rating Area 1	No Preference	48	555.47
73987DC0040029	Rating Area 1	No Preference	49	577.27
73987DC0040029	Rating Area 1	No Preference	50	599.91
73987DC0040029	Rating Area 1	No Preference	51	623.38
73987DC0040029	Rating Area 1	No Preference	52	647.70
73987DC0040029	Rating Area 1	No Preference	53	672.85
73987DC0040029	Rating Area 1	No Preference	54	699.26
73987DC0040029	Rating Area 1	No Preference	55	726.51
73987DC0040029	Rating Area 1	No Preference	56	755.02
73987DC0040029	Rating Area 1	No Preference	57	784.36
73987DC0040029	Rating Area 1	No Preference	58	814.97
73987DC0040029	Rating Area 1	No Preference	59	846.83
73987DC0040029	Rating Area 1	No Preference	60	879.95
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73987DC0040029	Rating Area 1	No Preference	62	913.90
73987DC0040029	Rating Area 1	No Preference	63	913.90
73987DC0040029	Rating Area 1	No Preference	64 and over	913.90
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73987DC0040046	Rating Area 1	No Preference	15	332.97
73987DC0040046	Rating Area 1	No Preference	16	332.97
73987DC0040046	Rating Area 1	No Preference	17	332.97
73987DC0040046	Rating Area 1	No Preference	18	332.97
73987DC0040046	Rating Area 1	No Preference	19	332.97
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73987DC0040046	Rating Area 1	No Preference	22	370.14

73987DC0040046	Rating Area 1	No Preference	23	370.14
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73987DC0040046	Rating Area 1	No Preference	25	370.14
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73987DC0040046	Rating Area 1	No Preference	32	415.96
73987DC0040046	Rating Area 1	No Preference	33	425.63
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73987DC0040046	Rating Area 1	No Preference	35	446.00
73987DC0040046	Rating Area 1	No Preference	36	456.18
73987DC0040046	Rating Area 1	No Preference	37	466.36
73987DC0040046	Rating Area 1	No Preference	38	471.96
73987DC0040046	Rating Area 1	No Preference	39	477.56
73987DC0040046	Rating Area 1	No Preference	40	496.40
73987DC0040046	Rating Area 1	No Preference	41	515.75
73987DC0040046	Rating Area 1	No Preference	42	536.11
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73987DC0040046	Rating Area 1	No Preference	46	624.70
73987DC0040046	Rating Area 1	No Preference	47	649.14
73987DC0040046	Rating Area 1	No Preference	48	674.60
73987DC0040046	Rating Area 1	No Preference	49	701.07
73987DC0040046	Rating Area 1	No Preference	50	728.57
73987DC0040046	Rating Area 1	No Preference	51	757.08
73987DC0040046	Rating Area 1	No Preference	52	786.61
73987DC0040046	Rating Area 1	No Preference	53	817.15
73987DC0040046	Rating Area 1	No Preference	54	849.23
73987DC0040046	Rating Area 1	No Preference	55	882.32
73987DC0040046	Rating Area 1	No Preference	56	916.94
73987DC0040046	Rating Area 1	No Preference	57	952.58
73987DC0040046	Rating Area 1	No Preference	58	989.75
73987DC0040046	Rating Area 1	No Preference	59	1028.44
73987DC0040046	Rating Area 1	No Preference	60	1068.67
73987DC0040046	Rating Area 1	No Preference	61	1109.91
73987DC0040046	Rating Area 1	No Preference	62	1109.91
73987DC0040046	Rating Area 1	No Preference	63	1109.91
73987DC0040046	Rating Area 1	No Preference	64 and over	1109.91
73987DC0040056	Rating Area 1	No Preference	0-14	217.44
73987DC0040056	Rating Area 1	No Preference	15	217.44
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73987DC0040056	Rating Area 1	No Preference	17	217.44
73987DC0040056	Rating Area 1	No Preference	18	217.44
73987DC0040056	Rating Area 1	No Preference	19	217.44
73987DC0040056	Rating Area 1	No Preference	20	217.44
73987DC0040056	Rating Area 1	No Preference	21	241.71
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73987DC0040056	Rating Area 1	No Preference	23	241.71
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73987DC0040056	Rating Area 1	No Preference	28	247.36
73987DC0040056	Rating Area 1	No Preference	29	252.68
73987DC0040056	Rating Area 1	No Preference	30	259.00
73987DC0040056	Rating Area 1	No Preference	31	265.65
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73987DC0040056	Rating Area 1	No Preference	33	277.95
73987DC0040056	Rating Area 1	No Preference	34	284.60
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73987DC0040056	Rating Area 1	No Preference	36	297.90
73987DC0040056	Rating Area 1	No Preference	37	304.55
73987DC0040056	Rating Area 1	No Preference	38	308.21
73987DC0040056	Rating Area 1	No Preference	39	311.86
73987DC0040056	Rating Area 1	No Preference	40	324.16
73987DC0040056	Rating Area 1	No Preference	41	336.80
73987DC0040056	Rating Area 1	No Preference	42	350.10
73987DC0040056	Rating Area 1	No Preference	43	363.73
73987DC0040056	Rating Area 1	No Preference	44	378.03
73987DC0040056	Rating Area 1	No Preference	45	392.66
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73987DC0040056	Rating Area 1	No Preference	47	423.91
73987DC0040056	Rating Area 1	No Preference	48	440.53
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73987DC0040056	Rating Area 1	No Preference	50	475.77
73987DC0040056	Rating Area 1	No Preference	51	494.39
73987DC0040056	Rating Area 1	No Preference	52	513.68
73987DC0040056	Rating Area 1	No Preference	53	533.63
73987DC0040056	Rating Area 1	No Preference	54	554.57
73987DC0040056	Rating Area 1	No Preference	55	576.18
73987DC0040056	Rating Area 1	No Preference	56	598.79
73987DC0040056	Rating Area 1	No Preference	57	622.06
73987DC0040056	Rating Area 1	No Preference	58	646.33
73987DC0040056	Rating Area 1	No Preference	59	671.60
73987DC0040056	Rating Area 1	No Preference	60	697.87
73987DC0040056	Rating Area 1	No Preference	61	724.80
73987DC0040056	Rating Area 1	No Preference	62	724.80

73987DC0040056	Rating Area 1	No Preference	63	724.80
73987DC0040056	Rating Area 1	No Preference	64 and over	724.80
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73987DC0040057	Rating Area 1	No Preference	15	252.13
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73987DC0040057	Rating Area 1	No Preference	18	252.13
73987DC0040057	Rating Area 1	No Preference	19	252.13
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73987DC0040057	Rating Area 1	No Preference	22	280.28
73987DC0040057	Rating Area 1	No Preference	23	280.28
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73987DC0040057	Rating Area 1	No Preference	29	293.00
73987DC0040057	Rating Area 1	No Preference	30	300.33
73987DC0040057	Rating Area 1	No Preference	31	308.04
73987DC0040057	Rating Area 1	No Preference	32	314.98
73987DC0040057	Rating Area 1	No Preference	33	322.30
73987DC0040057	Rating Area 1	No Preference	34	330.01
73987DC0040057	Rating Area 1	No Preference	35	337.72
73987DC0040057	Rating Area 1	No Preference	36	345.43
73987DC0040057	Rating Area 1	No Preference	37	353.14
73987DC0040057	Rating Area 1	No Preference	38	357.38
73987DC0040057	Rating Area 1	No Preference	39	361.62
73987DC0040057	Rating Area 1	No Preference	40	375.89
73987DC0040057	Rating Area 1	No Preference	41	390.54
73987DC0040057	Rating Area 1	No Preference	42	405.96
73987DC0040057	Rating Area 1	No Preference	43	421.77
73987DC0040057	Rating Area 1	No Preference	44	438.34
73987DC0040057	Rating Area 1	No Preference	45	455.31
73987DC0040057	Rating Area 1	No Preference	46	473.04
73987DC0040057	Rating Area 1	No Preference	47	491.55
73987DC0040057	Rating Area 1	No Preference	48	510.82
73987DC0040057	Rating Area 1	No Preference	49	530.87
73987DC0040057	Rating Area 1	No Preference	50	551.69
73987DC0040057	Rating Area 1	No Preference	51	573.28
73987DC0040057	Rating Area 1	No Preference	52	595.64
73987DC0040057	Rating Area 1	No Preference	53	618.77
73987DC0040057	Rating Area 1	No Preference	54	643.06
73987DC0040057	Rating Area 1	No Preference	55	668.12
73987DC0040057	Rating Area 1	No Preference	56	694.33
73987DC0040057	Rating Area 1	No Preference	57	721.32
73987DC0040057	Rating Area 1	No Preference	58	749.46
73987DC0040057	Rating Area 1	No Preference	59	778.76
73987DC0040057	Rating Area 1	No Preference	60	809.22
73987DC0040057	Rating Area 1	No Preference	61	840.45
73987DC0040057	Rating Area 1	No Preference	62	840.45
73987DC0040057	Rating Area 1	No Preference	63	840.45
73987DC0040057	Rating Area 1	No Preference	64 and over	840.45

SERFF Tracking #:	*AETN-131001834*	***State Tracking #:***		***Company Tracking #:***	*DCAHISG2018*

State:	*District of Columbia*	***Filing Company:***	*Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV*

TOI/Sub-TOI: *HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO*
Product Name: *DC AHI SG HMO 2018*
Project Name/Number: *2018 Exchange - Aetna/HMO*

Supporting Document Schedules

Bypassed - Item:	Actuarial Justification
Bypass Reason:	This is not a new form filing.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	DC SG State Actuarial Memo 1Q2018 - AHI.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum and Certifications
Comments:	
Attachment(s):	Actuarial Memorandum and Certification_DC AHI.pdf
Item Status:	
Status Date:	

Bypassed - Item:	Certificate of Authority to File
Bypass Reason:	The filing is being made by Aetna.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Consumer Disclosure Form
Comments:	
Attachment(s):	DC SG -AHI Part II Consumer Disclosure 1Q2018.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Cover Letter All Filings
Comments:	
Attachment(s):	DC SG SHOP Cover Letter - AHI 1Q18.pdf
Item Status:	
Status Date:	

SERFF Tracking #:	*AETN-131001834*	***State Tracking #:***		***Company Tracking #:***	*DCAHISG2018*

State:	*District of Columbia*	***Filing Company:***	*Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV*

TOI/Sub-TOI: *HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO*

Product Name: *DC AHI SG HMO 2018*

Project Name/Number: *2018 Exchange - Aetna/HMO*

Satisfied - Item:	DISB Actuarial Memorandum Dataset
Comments:	
Attachment(s):	DISB Actuarial Memo Dataset_AHI_2018 (w values).xlsx
Item Status:	
Status Date:	

Bypassed - Item:	District of Columbia and Countrywide Experience for the Last 5 Years (P&C)
Bypass Reason:	This is not a P & C Filing.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	District of Columbia and Countrywide Loss Ratio Analysis (P&C)
Bypass Reason:	This is not a P & C Filing.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Unified Rate Review Template
Comments:	
Attachment(s):	DC_SG_73987_URRT_ON_1Q2018_v1.pdf DC_SG_73987_URRT_ON_1Q2018_v1.xlsm
Item Status:	
Status Date:	

Satisfied - Item:	District of Columbia Plain Language Summary
Comments:	
Attachment(s):	DISB Plain Language Summary - AHI - 1Q2018.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Additional Supporting Documentation
Comments:	

SERFF Tracking #:	*AETN-131001834*	***State Tracking #:***		***Company Tracking #:***	*DCAHISG2018*

State:	*District of Columbia*	***Filing Company:***	*Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV*

TOI/Sub-TOI: *HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO*

Product Name: *DC AHI SG HMO 2018*

Project Name/Number: *2018 Exchange - Aetna/HMO*

Attachment(s):	Exhibit E-2 - Calc of Plan Adj Index Rates.pdf Exhibit 1 - Rate Increase by Product.pdf Exhibit 2 - Claim Impact due to Demo Changes.pdf Exhibit 3 - Projected Membership Dist by Area.pdf Exhibit 4 - Paid to Allowed by Metal Tier.pdf Exhibit 5 - Retention.pdf Exhibit 11 - Projected Age-Gender Dist.pdf Exhibit 12 - Comparison of Key Pricing Factors.pdf 2018Aetna AVCCert Template_AHI.pdf Exhibit A - Product Portfolio & Projected Membership Dist.pdf Exhibit A-1 - AHI Rate Change by plan.pdf Exhibit A-2 - AHI AV Screenshots.pdf Exhibit E-1 - Calc of Market Adj Index Rate.pdf Exhibit 6 - MLR Projection.pdf Exhibit 7 - Qtrly Trend Factors.pdf Exhibit 8 - Trend Exhibit.pdf Exhibit 9 - Sample Rate Calculation.pdf Exhibit 10 - Plan Mapping.pdf DISB Filing Checklist - AHI 2018.pdf
Item Status:	
Status Date:	

SERFF Tracking #:	AETN-131001834	**State Tracking #:**		**Company Tracking #:**	DCAHISG2018

State:	District of Columbia	**Filing Company:**	Aetna Health Inc. PA AZ DC DE IN KY MA MD NV NC OK TN VA WV
TOI/Sub-TOI:	HOrg02G Group Health Organizations - Health Maintenance (HMO)/HOrg02G.004F Small Group Only - HMO		
Product Name:	DC AHI SG HMO 2018		
Project Name/Number:	2018 Exchange - Aetna/HMO		

Attachment DISB Actuarial Memo Dataset_AHI_2018 (w values).xlsx is not a PDF document and cannot be reproduced here.

Attachment DC_SG_73987_URRT_ON_1Q2018_v1.xlsm is not a PDF document and cannot be reproduced here.

Aetna Health Inc. – District of Columbia
1Q18 Filing - Small Group Business
HIOS product ID: 73987DC004
Actuarial Memorandum

Statement of Purpose for Filing

This actuarial memorandum supports Aetna Health Inc. commercial base rates for District of Columbia small groups effective beginning January 1, 2018. The purpose of this memorandum is to comply with the District of Columbia, Department of Insurance, Securities and Banking, Health Insurance Rate Filing Procedures and to provide adequate supporting information for our proposed rates pursuant to the DC Official Code, Title 31, Subtitle IV, Chapter 34.

The requested rates have been developed incorporating consideration of the market changes and rating requirements taking effect in the Small Group market pursuant to the Patient Protection and Affordable Care Act of 2010 and subsequent regulation. They are compliant with all rating limitations under federal and state regulation. The plan designs contained in this submission are to be sold on the Exchange.

The descriptions and analyses presented in this rate filing reflect our current understanding of regulations and guidance. As further guidance is received, we reserve the right to submit revisions or withdraw this rate filing.

Summary of Changes from prior filing and rate manual

We are proposing to revise the quarterly premium rates for effective dates from January 1, 2018, through December 31, 2018. The quarterly rate increases are reflected in Exhibit 7. Generally, rate changes do not vary by plan design, with the exception of the impact associated with plan-specific benefit modifications necessary to comply with Actuarial Value requirements.

Rates for the plans in this submission are being revised to reflect 1) the impact of updated experience data and medical claim trend and 2) changes in cost-sharing levels to ensure that plans comply with Actuarial Value requirements.

There are no other proposed changes for this submission.

Form Numbers

An exhibit showing the Form Numbers is shown on under the “Certificate of Form Names and Numbers” Exhibit of this Actuarial Memorandum.

Status of Forms

The forms for this submission are "open to new sales" and "non-grandfathered".

Description of Benefits/Metal Levels and Actuarial Values

This filing covers HMO group medical benefit coverage. The range of coverage includes inpatient, outpatient, primary care, specialist services, pharmacy, DME, and vision. Information on the cost-sharing parameters of the covered benefit plans, including deductibles and copays, can be found in the Schedule of Benefits in the Form filing (AETN-130955797). All benefits are compliant with state mandates and the requirements of the Patient Protection and Affordable Care Act of 2010, including preventive care benefits, deductible limits, and Actuarial Value requirements.

Exhibit A shows the metal level and actuarial value for each plan design using the AV calculator developed and made available by HHS.

Average Rate Increase Requested

The following tables provide the requested weighted average increases. The first table shows the incremental increase and the second table shows the year over year increase.

	1Q18/4Q17	2Q18/1Q18	3Q18/2Q18	4Q18/3Q18
Incremental Rate Increase	0.60%	2.60%	2.60%	2.60%

	1Q18/1Q17	2Q18/2Q17	3Q18/3Q17	4Q18/4Q17	Average
Requested Rate Increase	10.20%	9.70%	9.20%	8.70%	9.40%

Maximum Rate Increase Requested

The maximum rate increase that could be applied to a policyholder based on changes to the base rate and rate factors is 18.10%. This rate increase applies to members renewing in 1Q18 for the DC Gold HMO 1600 100% HSA T plan (HIOS ID 73987DC0040046).

Minimum Rate Increase Requested

The minimum rate increase that could be applied to a policyholder based on changes to the base rate and rate factors is 7.40%. This rate increase applies to members renewing in 4Q18 for the DC Gold HMO 500 90% plan (HIOS ID 73987DC0040021).

Absolute Maximum Premium Increase

The absolute maximum year-over-year renewal rate increase that could be applied to a policyholder, including demographic changes like aging, is 31.20%. This rate increase applies to members renewing in 1Q18 for the DC Gold HMO 1600 100% HSA T (HIOS ID 73987DC0040046) that age up from 20 to 21.

Average Renewal Rate Increase for a Year

The average renewal rate increase, weighted by written premium, for renewals in the year ending with the effective period of the rate filing is 9.40%

Rate Change History

The rate change history for the forms referenced in the filing is shown below.

Rate Effective Date	Annual Total Change
4Q16	2.2%
1Q17	7.6%
2Q17	8.4%

3Q17	9.1%
4Q17	10.1%

Exposure

The current exposure as of December 2016 is 43 policies, 290 certificates, and 410 covered lives.

Member Months

The numbers of members in force during each month of the base experience used in the rate development and for the preceding 12 month period for the forms referenced in this filing are shown in the Loss Ratio History Exhibit of the Actuarial Memorandum.

Past Experience

The monthly earned premium and incurred claims for the base experience period used in the rate development and for the preceding 12 month period for the forms referenced in this filing are shown in the Loss Ratio History Exhibit of the Actuarial Memorandum.

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Index Rate

The index rate = $421.67.

Rate Development

Determination of Claim Portion of Market Index Rate

In setting the projected claim level in the market in 2018, we based our projections upon the 2016 experience of our current ACA small group block of business for Innovation Health Plan, Inc. and Innovation Health Insurance Company, in the 2-50 market. The experience data utilized in the rate development reflects incurred claims from January 1, 2016 to December 31, 2016 and paid through February 2017. This manual experience is the HMO Small Group Experience for Innovation Health Plan, Inc. and PPO Small Group Experience for Innovation Health Insurance Company in Northern Virginia.

The manual experience used to develop the rates is shown below:

DOS	Membership	Claims	Premium *	Loss Ratio
01/01/2016	21,646	5,255,368	8,167,087	64.3%
02/01/2016	21,711	5,933,277	8,168,857	72.6%
03/01/2016	21,795	5,896,316	8,208,103	71.8%
04/01/2016	21,851	6,092,616	8,249,863	73.9%
05/01/2016	21,916	5,577,664	8,283,624	67.3%
06/01/2016	21,960	5,784,314	8,320,512	69.5%
07/01/2016	21,941	5,588,085	8,327,574	67.1%
08/01/2016	21,934	6,262,822	8,350,500	75.0%
09/01/2016	22,040	5,481,300	8,391,789	65.3%
10/01/2016	21,969	5,509,391	8,392,750	65.6%
11/01/2016	22,043	6,328,112	8,434,443	75.0%
12/01/2016	22,314	6,524,386	8,645,272	75.5%
Total	**263,120**	**70,233,651**	**99,940,375**	**70.3%**

*Note: Premiums shown are not risk adjusted. The current estimate of the 2016 risk adjusted loss ratio is 78%.

Total incurred claims are developed by estimating the incurred but not paid (IBNP) reserves using aggregate block of business paid claims. Paid claims are adjusted using the IBNP completion factors. More specifically, historical claim payment patterns are used to predict the ultimate incurred claims for each date-of-service month. The IBNP is estimated using actuarial principles and assumptions which consider historical claim submission and adjudication patterns, unit cost and utilization trends, claim inventory levels, changes in membership and product mix, seasonality, and other relevant factors including a review of large claims. This same process is used to develop IBNP estimates for allowed claims.

As noted above, the experience period reflects two months of paid claim run-off. The IBNP reserves account for approximately 4.0% of the experience period incurred claims.

For the projection, the following was taken into consideration:

A. Changes in the Morbidity of the Population Insured:

The experience period data includes experience for policies issued to small employers in 2015 and 2016. We considered the expected relationships between the morbidity of the experience policies and the likely population that will be covered by Small Group Single Risk Pool policies in 2018.

B. Changes in Benefits:

The products included in this filing include benefits necessary to comply with the Essential Health Benefit requirements. The experience data includes experience for Single Risk Pool products that have essentially identical benefits.

The change in projected utilization due to changes in benefits is also considered. As cost sharing decreases (measured by increasing Actuarial Value), utilization increases. This pattern is reflected in the factors that are built into the federal risk adjustment mechanism that started in 2014. The federal risk adjustment program factors and other proprietary models were considered in the development of the utilization change. The average cost sharing in the experience period was compared with the average cost sharing in the projection period. From the average cost sharing change, an expected utilization change was derived.

C. Changes in Demographics:

Experience data was normalized for projected changes in the age/gender mix and area mix using internally-developed factors. Exhibits 2 and 3 contain detail on the calculations of the impact of demographic mix shifts.

D. Other Adjustments:

The ‘Other’ adjustment includes the projected impact of changes in network composition and provider contracts.

Determination of Retention Portion of Market Index Rate

The retention portion of the projected premium is illustrated in Exhibit 5.

The prospective general and administrative expenses are based on historical corporate small group market expense levels, current-year projections, and projected changes in expenses, inflation, and membership for 2018. The commission expense factor covers anticipated sales and marketing expenses. Those may include, without limitation, purchase of television, internet and other advertising; payments of commissions and other incentive compensation to Company’s internal sales force; and payment of commissions to external brokers. The exact amounts and distribution among the categories of sales and marketing expenses will depend on a variety of factors including competitive conditions, business strategy, consumer behaviors, and legal and regulatory requirements. The consumer

behaviors would capture whether they use a particular distribution channel, commissioned or not, as well as their experience.

Federal taxes include PPACA Taxes and Fees are based on the Notice of Benefit and Payment Parameters for 2018, as well as Federal income tax. The risk adjustment user fee is applied to the projected risk adjustment transfer and therefore, excluded from the taxes and fees shown under non-benefit expenses. State premium taxes are estimated on most current known levels and include any known assessments.

The profit and risk load is consistent with the target used in pricing our 2017 plans.

Requested Rates

Rates are determined using the prescribed member build-up approach. In the event that a family includes more than three dependents under age 21, only the three oldest dependents will be considered in determining the family's premium. Additional dependents (non-billable members) will not be included in the rate calculation.

The premium for each billable member is calculated as:
Calibrated Plan Adjusted Index Rate * Age Factor * Area Factor * Trend Factor

The resulting rate is rounded to the nearest cent, and rates are then summed for all billable family members.

An example of a contract's premium determined by the member build-up calculation is shown in Exhibit 9.

Credibility Assumption

No credibility is assigned to the experience data for the District of Columbia. This is due to the use of alternate experience data that more accurately captures the essential characteristics of the market for which we are developing rates.

Trend Assumption

Anticipated annual trend from the experience period to the rating period for the product line is shown in the following table. The table shows the trend assumptions by major types of service as defined by HHS, separately by unit cost, utilization, and in total.

Type of Service	Unit Cost	Utilization	Leveraging	Total
Inpatient Hospital	6.0%	2.4%	1.1%	9.6%
Outpatient Hospital	4.9%	6.4%	1.4%	13.2%
Professional	1.8%	4.4%	1.0%	7.3%
Other Medical	4.9%	6.4%	1.4%	13.2%
Capitation	0.0%	N/A	0.0%	0.0%
Prescription Drug	7.7%	4.0%	2.5%	14.8%
Total	**4.6%**	**4.5%**	**1.5%**	**10.9%**

a. Medical Trend
Allowed medical trend includes known and anticipated changes in provider contract rates, severity and medical technology impacts, and expected changes in utilization. The impact of benefit leveraging is accounted for separately in the projected paid to allowed ratio.

b. Pharmacy Trend
Pharmacy trend considers the impact of formulary changes, patent expirations, new drugs, other general market share shifts, and overall utilization trend.

Cost-sharing changes & Benefit Changes

Aetna's rate review models project incurred claims and earned premiums assuming a static benefit plan mix for the book of business for the experience period. Since Aetna prices the book of business utilizing a target loss ratio approach, adjustments made to the incurred claims and earned premiums to account for the anticipated changes to the plan mix would offset resulting in the same projected loss ratio. The Plan Relativity Factors adjust future premium levels to align with the expected claims for changes in plan mix for future dates of service.

Plan Relativities

The Plan Relativities represent the expected value of the difference in benefits and networks between the market index rate and each additional proposed benefit plan discussed in this filing. The relativities were developed using a proprietary pricing model which relies on State- and product-specific benefit service category weights and rating factors for various levels of plan/member cost-sharing options for deductibles, coinsurance, out-of-pocket maximums and copays.

The product-specific service category weights were developed based on the experience of Aetna's Small Group block of business. The cost-sharing-specific rating factors were developed using experience associated with our Large Group block of business, which excludes the effects of selection. These Large Group based cost-sharing specific rating factors account for differences in a standard population's spending patterns due to differences in the richness and/or structure of benefits, or induced demand, without reflection of differences in health status.

Final plan relativities reflect the value of the EHB and state mandated benefits (including pediatric dental), incorporating the impact of out-of-network benefits and additional benefits. The methodology also considers the value of any differences in network by plan, including but not limited to network discounts and steerage.

The Plan Relativities for each plan are shown in the AV Pricing Value Column of Exhibit E-2.

Rating Factors

<u>Effective Date Factors</u>
Exhibit 7 illustrates the quarterly trend factors, the resulting index rate for effective dates during each calendar quarter, the projected membership distribution by effective date, and the weighted-average index rate. Trend factors are developed from annual forward trend, and leveraging. A trend factor of 1.00 corresponds to a policy period that begins January 1, 2018.

<u>Member Age Factor</u>
The age factors are based on the DC specific age scale. The factors are shown in Exhibit 11.

<u>Tobacco Factors</u>
No load is proposed for tobacco users.

Area Factors
Exhibit 3 summarizes the rating area definitions and factors, and displays the projected membership by area to develop the projected average area factor. The geographic calibration factor is the reciprocal of the projected average area factor.

Wellness Programs

Aetna may encourage and incent members to access certain medical services, to use online tools that enhance their coverage and services, and to continue participation as an **Aetna** member. Members and their doctor can talk about these medical services and decide if they are right for the member. Aetna may also encourage and incent members in connection with participation in a wellness or health improvement program. Incentives include but are not limited to:

- Modification to **copayment**, **deductible** or **coinsurance** amounts
- **Premium** discounts or rebates
- Contributions to health savings account
- Fitness center membership reimbursement
- Merchandise
- Coupons
- Gift cards
- Debit cards
- Any combination of the above

The award of any such incentive shall not depend upon the result of a wellness or health improvement activity or upon a member's health.

Distribution of Rate Increases

The distribution of rate increases (annual) is shown in Exhibit A-1. The increases are shown by Plan.

Claim Reserve Needs

Total incurred claims are developed by estimating the incurred but not paid (IBNP) reserves using aggregate block of business paid claims. Paid claims are adjusted using the IBNP completion factors. More specifically, historical claim payment patterns are used to predict the ultimate incurred claims for each date-of-service month. The IBNP is estimated using actuarial principles and assumptions which consider historical claim submission and adjudication patterns, unit cost and utilization trends, claim inventory levels, changes in membership and product mix, seasonality, and other relevant factors including a review of large claims. This same process is used to develop IBNP estimates for allowed claims.

The experience data reflects incurred claims from January 1, 2016 through December 31, 2016 and paid through February 28, 2017. The paid claims for the DC Base experience period are $1,294,430. The estimated incurred claims are $1,588,364.

Administrative Costs of Programs that Improve Health Care Quality

The administrative costs included with claims in the numerator of the MLR calculation are shown in Exhibit 6 (MLR Projection).

Taxes and Licensing or Regulatory Fees

The taxes, licenses and fees removed from premium in the denominator of the MLR calculation are shown in Exhibit 6 (MLR Projection).

Medical Loss Ratio (MLR)

The projected Medical Loss Ratio (MLR) as defined by HHS is 84.10% and meets the minimum MLR requirements of Insurance Art. § 15-605(c). The details of the MLR calculation are shown in Exhibit 6 (MLR Projection).

Risk Adjustment

Risk Adjustment – Experience Period

Risk Adjustment transfer is accrued at the issuer and market level based on 2016 Wakely data. The transfer is allocated to the member-level based by applying the HHS risk transfer calculation to each member relative to the imputed market average; such that members with higher resulting relative transfer scores may have a receivable and members with lower resulting scores may have a payable, regardless of the net market risk transfer result. The resulting member transfers are summed to the HIOS plan level and adjusted for 2016 Risk Adjustment fees of $0.14 PMPM in Worksheet 2.

Risk Adjustment – Projection Period

Aetna is projecting a risk adjustment payable. We expect that we will have membership enrolled under the market average morbidity. The resulting PMPM adjustment, net of risk adjustment user fees, is $19.76 PMPM.

Reinsurance

Transitional Reinsurance recoveries do not apply to Small Group business. The experience period data reflects the Reinsurance Contribution of $2.25 PMPM assessed during 2016.

Risk Corridor

The Risk Corridor program does not apply to Small Group business.

Past and Prospective Loss Experience Within and Outside the State

The loss experience used in the development of the rates was based on the HMO Small Group Experience for Innovation Health Plan, Inc. and PPO Small Group Experience for Innovation Health Insurance Company in Northern Virginia.

Reasonable Margin for Reserve Needs & Past and Prospective Expenses

The retention portion of the projected premium is illustrated in Exhibit 5.

The prospective general and administrative expenses are based on historical corporate small group market expense levels, current-year projections, and projected changes in expenses, inflation, and membership for 2018. The commission expense factor covers anticipated sales and marketing expenses. Those may include, without limitation, purchase of television, internet and other advertising; payments of commissions and other incentive compensation to the Company's internal sales force; and payment of commissions to external brokers. The exact amounts and distribution among the categories of sales and marketing expenses will depend on a variety of factors including competitive conditions, business strategy, consumer behaviors, and legal and regulatory requirements. The consumer behaviors would capture whether they use a particular distribution channel, commissioned or not, as well as their experience.

Federal taxes include PPACA Taxes and Fees are based on the Notice of Benefit and Payment Parameters for 2018, as well as Federal income tax. The risk adjustment user fee, as previously

mentioned in the Risk Adjustment section, is applied to the projected risk adjustment transfer and therefore, excluded from the taxes and fees shown under non-benefit expenses. State premium taxes are estimated on most current known levels and include any known assessments.

The profit and risk load is consistent with the target used in pricing our 2017 plans.

Any Other Relevant Factors Within and Outside the State

All relevant Factors within and outside the State have been considered in the development of the proposed rates.

Any other information needed to support the requested rates or to comply with Actuarial Standard of Practice No. 8

This filing is in conformity with all the applicable Actuarial Standards of Practice, including ASOP No. 8.

Addition of Newly-Requested Exhibit for 2018

The following exhibit new to 2018 was requested:
DISB will require all issuers of Qualified Health Plans (for sale on DC HealthLink) to provide a chart containing clear and concise information on the following:

1) *Any and all components of requested changes in the rates from the prior year, such as trends, risk adjustment, age calibration, mapping from a different plan, etc. (this is not meant to be an exhaustive list; your list should contain all applicable components);*
2) *A quick summary/explanation of the change associated with each listed component; and*
3) *The actual percentage impact of the change to each component, such that the sum total for all components equals the total percentage change requested for the plan year.*

We have included our response to this request as Exhibit 12.

Actuarial Certification

I, Erica A. Mitchell, am an employee of Aetna Inc. and a member of the American Academy of Actuaries. I have reviewed the enclosed rates submitted by Aetna Health Inc. for the District of Columbia.

These rates reflect the negotiated prices from the provider contracts and the expected utilization experience of the plan.

I relied upon financial records and summaries prepared by responsible officers and employees of Aetna Health Inc. In other respects, my analysis included review of assumptions that I considered necessary.

For preparation of the rates, items identified above:

(i). are computed in accordance with commonly accepted actuarial standards consistently applied and are fairly stated in accordance with sound actuarial principles,

(ii). meet the requirements of Washington D.C,

(iii). make a good and sufficient provision for all unpaid claims of the organization under the terms of its contracts and agreements, and

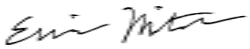
(iv). include appropriate provision for all actuarial items which ought to be established where allowed by law.

A target medical loss ratio of 75.00% was used for this filing calculated in the traditional way. The expected 2018 MLR for this filing, as defined by PPACA and before any credibility adjustment, is 84.10%.

These rates are appropriate for quotes delivered for effective dates beginning January 1, 2018. The proposed change is an increase greater than the 10% threshold and will trigger the federal review requirements as specified under 45 CFR Part 154.

This rate filing conforms to the benefit plan provisions required by the Patient Protection and Affordable Care Act (P.L. 111-148) of 2010.

In my opinion, the enclosed rates are reasonable in relation to the anticipated experience of Aetna Health Inc. They are neither excessive nor inadequate, nor unfairly discriminatory.



_____ May 1, 2017

Erica A. Mitchell, FSA, MAAA Date
Aetna Health Inc.

District of Columbia Small Group
AHI (HMO plans) Loss Ratio History

DOS	Membership	Claims	Premium*	Loss Ratio
01/01/2015	688	$123,066	$268,837	45.8%
02/01/2015	675	$78,619	$265,771	29.6%
03/01/2015	654	$118,161	$257,598	45.9%
04/01/2015	619	$114,582	$243,931	47.0%
05/01/2015	616	$76,670	$242,154	31.7%
06/01/2015	588	$125,010	$233,789	53.5%
07/01/2015	575	$96,078	$228,261	42.1%
08/01/2015	579	$144,652	$230,112	62.9%
09/01/2015	521	$48,341	$208,229	23.2%
10/01/2015	514	$116,154	$206,998	56.1%
11/01/2015	510	$151,221	$201,691	75.0%
12/01/2015	505	$51,829	$199,737	25.9%
01/01/2016	469	$55,886	$188,707	29.6%
02/01/2016	472	$105,358	$191,400	55.0%
03/01/2016	472	$86,818	$191,749	45.3%
04/01/2016	467	$101,852	$190,502	53.5%
05/01/2016	472	$103,794	$192,535	53.9%
06/01/2016	469	$125,823	$191,201	65.8%
07/01/2016	462	$121,854	$188,744	64.6%
08/01/2016	454	$144,998	$184,665	78.5%
09/01/2016	447	$101,224	$181,811	55.7%
10/01/2016	444	$203,118	$179,842	112.9%
11/01/2016	425	$310,211	$170,538	181.9%
12/01/2016	410	$127,429	$164,059	77.7%
CY 2015	7,044	$1,244,382	$2,787,109	44.6%
CY 2016	5,463	$1,588,364	$2,215,754	71.7%

*Note: Premiums shown are not risk adjusted. The current estimate of the 2016 risk adjusted loss ratio is 95.00%.

Certificate Form Names and Numbers

Form Name	*Form Number*
HI DC SG HHIXCOC V002	HI SG HCOC 2018 02-HIX
HI DC HGrpAg V003	HI SG HGrpAg 03

Schedule Form Names and Numbers

Form Name	*Form Number*
HI DC SG-HIXSOB-14038682 V002	HI SG-SOB-14038682 02-HIX
HI DC SG-HIXSOB-14038683 V002	HI SG-SOB-14038683 02-HIX
HI DC SG-HIXSOB-14038684 V002	HI SG-SOB-14038684 02-HIX
HI DC SG-HIXSOB-14038685 V002	HI SG-SOB-14038685 02-HIX
HI DC SG-HIXSOB-14038686 V002	HI SG-SOB-14038686 02-HIX
HI DC SG-HIXSOB-14038687 V002	HI SG-SOB-14038687 02-HIX

Actuarial Memorandum and Certification

General Information

Company Identifying Information:

Company Legal Name:	**Aetna Health Inc.**
State:	**District of Columbia**
HIOS Issuer ID:	**73987**
Market:	Small Group
Effective Date:	01/01/2018
Rate Filing Tracking Number:	**AETN-131001834**
Policy Form(s):	
Form Filing Tracking Number:	**AETN-130955797**

Company Contact Information:

Name:	**Diane Anderson**
Telephone Number:	**(860)273-3188**
Email Address:	**AndersonD1@aetna.com**

1. Purpose, Scope, and Effective Date

The purpose of this filing is to:

1) Provide support for the development of the Part I Unified Rate Review Template;
2) Provide support for the assumptions and premiums rate development for the products supported by the policy forms referenced above;
3) Request approval of the proposed monthly premium rates; and
4) Provide benefit plan designs summaries for the products included in this filing.

The development of the rates reflects the impact of the market forces and rating requirements associated with the Patient Protection and Affordable Care Act (PPACA) and subsequent regulation.
These rates are for plans issued in District of Columbia beginning January 1, 2018. The rates comply with all rating guidelines under federal and state regulations. The filing covers plans that will be offered outside the public Marketplace in District of Columbia.

2. Proposed Rate Increase

Monthly premium rates for Small Group Market products in District of Columbia are being revised for effective dates January 1, 2018 through December 31, 2018.

A. Reason for Rate Increase(s):

- Impact of medical claim trend (including changes in provider unit costs and increased utilization of medical cost services) and pharmacy trend;
- Revisions to our assumptions about market-wide population morbidity and the projected population distribution;
- Re-instatement of the Health Insurers Fee after a 1-year hiatus in 2017;
- Addition of High Risk Enrollee pooling to Risk Adjustment program;
- Revisions to administrative expense projections;
- Modifications in cost sharing to ensure that plans comply with Actuarial Value requirements;
- Updates to our pricing models used to determine the impact of cost sharing designs; and

- Changes in provider networks and contracts.

B. Variation in Rate Changes by Plan/Product:
Rate changes differ by plan for the following reasons:

- Modification to cost sharing differs by plan in order to maintain compliance with Actuarial Value and other regulatory requirements.
- Our internal pricing models have been updated to reflect more current information on levels of induced demand associated with different benefit designs. These changes impact our estimates of the relative costs of the plan designs that will be offered.

Exhibit 1 shows the average threshold increases for products covered by this filing.

3. Experience Period Premium and Claims

A. Paid Through Date:
The experience data reported in Worksheet 1, Section I of the Part I Unified Rate Review Template reflects incurred claims from January 1, 2016 through December 31, 2016 and paid through February 28, 2017.

B. Premiums (Net of MLR Rebate) in Experience Period:
Experience period premiums are date-of-service premiums from our actuarial experience databases for non-grandfathered Small Group business in District of Columbia. Our internal projections indicate that no MLR rebate is expected to be paid in 2017 (for 2016 experience) for the Small Group MLR Pool in District of Columbia. As such, no adjustment was made to premiums to account for expected rebates.

C. Allowed and Incurred Claims Incurred During the Experience Period:
Allowed and incurred claims are sourced from our actuarial experience databases. These databases provide member-level detail on total allowed and incurred claims but do not include unit cost or utilization metrics. We allocate claims to cost categories and estimate the corresponding unit costs and utilization metrics by using an alternate reporting system that calculates unit cost and utilization metrics by medical cost category but only permits inclusion/exclusion of experience at the market and segment levels. A reconciliation of aggregate data in our actuarial experience databases is performed to ensure that data is consistent with the experience data contained in our enterprise-wide data warehouse.

Total incurred claims are developed by estimating the incurred but not paid (IBNP) reserves using aggregate block of business paid claims. Paid claims are adjusted using the IBNP completion factors. More specifically, historical claim payment patterns are used to predict the ultimate incurred claims for each date-of-service month. The IBNP is estimated using actuarial principles and assumptions which consider historical claim submission and adjudication patterns, unit cost and utilization trends, claim inventory levels, changes in membership and product mix, seasonality, and other relevant factors including a review of large claims. This same process is used to develop IBNP estimates for allowed claims.

As noted above, the experience period reflects two months of paid claim run-off. The IBNP reserves account for approximately 15% of the experience period incurred claims. The reserving factor is higher-than-average due to small block size coupled with large claims reserves. Please note that our 2018 projection is based on the experience of a much larger block of business, as discussed in section 6.

4. Benefit Categories

Our internal systems assign claims to several benefit categories. We have mapped these categories to the categories described in the Unified Rate Review Instructions released in April, 2017. Inpatient Hospital consists of care delivered at an inpatient facility and associated expenses, included day-based mental

health services. Outpatient Hospital includes outpatient surgical, outpatient mental health, and emergency care and associated expenses. Professional includes both specialty physician and primary care physician expenses, including office-based mental health services. Other includes dental, home health care, medical pharmacy expenses, laboratory expenses, and radiology expenses. Non-capitated ambulance is included in the Outpatient Hospital category when billed by the facility and included in Specialist Physician otherwise. Prescription Drug includes drugs dispensed by a pharmacy.

The utilization for these services are counted by service type, and aggregated for each benefit category. Inpatient Hospital utilization is counted as days; Outpatient Hospital, Professional, and Other Medical utilization are counted as visits. Prescription Drug utilization is counted per script.

5. Projection Factors

A. Changes in the Morbidity of the Population Insured:

The experience period data includes experience for community-rated policies issued to small employers in 2015 (with services in 2016) and 2016.

We also considered the expected morbidity of the DC small group ACA population and the likely population that will be covered by Small Group Single Risk Pool policies in 2018 and have adjusted our projections for this morbidity change accordingly.

B. Changes in Benefits:

The products included in this filing include benefits necessary to comply with the Essential Health Benefit requirements. The experience data includes experience for Single Risk Pool products that have essentially identical benefits and coverage.

The change in projected utilization due to changes in benefits is also considered. As cost sharing decreases (measured by increasing Actuarial Value), utilization increases. This pattern is reflected in the factors that are built into the federal risk adjustment mechanism that started in 2014. The federal risk adjustment program factors and other proprietary models were considered in the development of the utilization change. The average cost sharing in the experience period was compared with the average cost sharing in the projection period. From the average cost sharing change, an expected utilization change was derived.

C. Changes in Demographics:

Experience data was normalized for projected changes in the age/gender mix and area mix using internally-developed factors. Exhibits 2 and 3 contain detail on the calculations of the impact of demographic mix shifts.

D. Other Adjustments:

The 'Other' adjustment includes the projected impact of changes in network composition and provider contracts, expected morbidity changes, changes in benefits, and changes in demographics.

E. Trend Factors (Cost/Utilization):

Medical trend factors are based on our Medical Economics Unit's national guidance coupled with local trend and network experience, based on analysis of a continuous normalized population, excluding catastrophic claims. Allowed medical trend includes known and anticipated changes in provider contract rates, severity and medical technology impacts, and expected changes in utilization. The impact of benefit leveraging is accounted for separately in the projected paid to allowed ratio.

Pharmacy trends are based on national commercial group Rx trend analysis. Pharmacy trend considers the impact of formulary changes, patent expirations, new drugs, other general market share shifts, and overall utilization trend. Pharmacy Trend is expressed in terms of allowed trend less rebates.

Exhibit 8 shows the anticipated annual trend from the experience period to the rating period.

6. Credibility Manual Rate Development

A. Source and Appropriateness of Experience Data Used:

The source data for our manual rate is the experience incurred from January 1, 2016 to December 31, 2016 and paid through February, 2017 for issuers 86443 and 12028 in the Virginia Small Group (HMO & PPO) market. This manual experience is the HMO and PPO Small Group Experience for Innovation Health Plan, Inc. and Innovation Health Insurance Company respectively, in Northern Virginia. The manual experience is considered an appropriate source for the manual rate due to similarities in covered benefits and market dynamics to the current ACA Small Group market. The similar dynamics include: no individual medical underwriting and rating by gender, limits on age-rating, and caps for rating on the number of dependents, as well as plans benefits and cost-sharing.

B. Adjustments Made to the Data:

The Small Group experience used as the basis for the manual rate was adjusted in a similar manner as the base period experience for changes in population risk morbidity, benefits, and demographic and area normalizations. The data is further adjusted for projected changes in network, provider contract rates, and claims adjudication, in addition to unit cost and utilization trend.

C. Inclusion of Capitation Payments:

No services provided in 2018 will be covered by capitation arrangements.

7. Credibility of Experience

No credibility is assigned to the experience data. This is due to the use of alternate experience data that more accurately captures the essential characteristics of the market for which we are developing rates.

8. Paid-to-Allowed Ratio

The projected paid to allowed ratio is 79.6%. Paid to allowed ratios are based on 2016 experience that is adjusted for the impact of any plan benefit changes based on our internal pricing models and trend deductible-leveraging.

9. Reinsurance and Risk Adjustment

A. Reinsurance – Experience Period

Transitional Reinsurance recoveries do not apply to Small Group business. The experience period data reflects the Reinsurance Contribution of $2.25 PMPM assessed during 2016.

B. Risk Adjustment – Experience Period

Risk Adjustment transfer is accrued at the issuer and market level based on 2016 Wakely data and our internal projections of how our risk relative to market has changed since that report was issued. The transfer is allocated to the member-level based by applying the HHS risk transfer calculation to each member relative to the imputed market-average, such that members with higher resulting relative transfers scores may have a receivable and members with lower resulting scores may have a payable, regardless of the net market risk transfer result. The resulting member transfers are summed to the HIOS plan level and adjusted for 2016 Risk Adjustment fees of $0.15 PMPM in Worksheet 2.

C. Risk Adjustment – Projection Period

We started with 2016 Risk Adjustment accruals to determine our current risk transfer relative to the market. The difference between our projected relative risk and the market's is multiplied by the projected market average premium, which we trended at 10% for 2017, and 10% for 2018. To determine the average premium increase for 2017, we looked at the 2017 benchmark plan's increase that was published in the (10/24/2016) ASPE Research Brief titled "Health plan Choice and Premiums in the 2017 Health Insurance Marketplace". For the 2018 market average premium increase, we assumed trend and the reinstatement of the HIF would increase premiums, but did not assume further market corrections.

In addition, the projected risk adjustment transfer includes changes that were outlined in the 2018 Notice of Benefit and Payment Parameters. The 2018 projected market average premium used in the payment transfer formula is also reduced by 14% to remove administrative cost. To that transfer, we subtracted to that Risk Adjustment transfer 0.5% of premiums for National High Risk pool funding, and added our anticipated High Risk Pool recoveries. High Risk Pool recoveries were estimated based on the average of member-level recoveries that we would have received under this program for 2014-2016 claims as a percent of premium, for Silver Off-Exchange plans.

As a result, we project a risk adjustment payable, net of the 2018 user fee of $0.14 PBMPM. The resulting PMPM adjustment, net of risk adjustment user fees, is $19.76.

10. Non-Benefit Expenses and Profit & Risk

The retention portion of the projected premium is illustrated in Exhibit 5.

Actual general and administrative expenses are based on historical corporate Small Group market expense levels, 2017 projections, and projected changes in expenses, inflation, and membership for 2018 for our National book of Small Group business.

A flat commission per policy per month will be paid to all brokers in the District of Columbia during open enrollment. Commissions do not vary by plan.

Federal taxes include PPACA Taxes and Fees are based on the Notice of Benefit and Payment Parameters for 2018, as well as Federal income tax and State Premium taxes. The risk adjustment user fee, as previously mentioned in Section 9, is applied to the projected risk adjustment transfer and therefore, excluded from the taxes and fees shown under non-benefit expenses. State premium taxes are estimated on most current known levels and include any known assessments.

The profit and risk load is consistent with the target used in pricing our 2017 plans.

11. Projected Loss Ratio

The expected 2018 MLR for this filing, as defined by PPACA and before any credibility adjustment, is shown in Exhibit 6.

12. Single Risk Pool

The plans and rates included in the Part I URRT are those for all plans we intend to offer in the Small Group market in the District of Columbia through Aetna Health Inc. The proposed rates comply with the Single Risk Pool requirements of 45 CFR §156.80(d).

13. Index Rate

The index rates for the experience and projection periods are set equal to the actual and projected allowed claims, respectively, less non-essential health benefits.

The index rate reflects the projected mix of business by plan. The AV pricing values for each plan are based on our internal company modeling of plan cost-sharing designs, the plan's provider network, delivery system characteristics, and utilization management practices, the impacts (as applicable) of benefits in addition to EHBs and catastrophic eligibility criteria, and the distribution and administrative costs applicable to the plan/product. Rates do not differ for any characteristic other than those allowable under the regulations as described in 45 CFR 156 §156.80(d)(2).

Small Group Market Trend Adjustments: Exhibit 7 illustrates the quarterly trend factors, the resulting index rate for effective dates during each calendar quarter, the projected membership distribution by effective date, and the weighted-average index rate. A trend factor of 1.00 corresponds to a policy period that begins January 1, 2018.

14. Market-Adjusted Index Rate

Exhibit E-1 illustrates the development of the Market Adjusted Index Rate. The market-wide adjustment for Risk Adjustment was discussed, previously. The risk adjustment on is displayed on a paid-basis and the exchange user fee is estimated as a PMPM based on the target premium rate on Worksheet 1 of the URRT. These values have been have each been converted to percent of allowed claims in this Exhibit.

15. Plan-Adjusted Index Rates

Exhibit E-2 illustrates the development of the Plan Adjusted Index Rates, and displays each plan-specific adjustment made to the Market Adjusted Index Rate. The 2018 Plan Adjusted Index Rates are displayed in Column 7. The following briefly describes how each set of adjustments was determined.

A. Actuarial Value, Cost Sharing:

The factors in Column 2 are the product of two separate adjustments:

1. We used internal models developed on large group claims experience to estimate the impact of different cost sharing designs. The combination of these two analyses is a projection of the relative paid to allowed ratio which also reflects the impact of out of network coverage.
2. We applied an adjustment for the impact different levels of cost sharing have on the use of medical services, which is based in part on the induced utilization factors used in the Risk Adjustment program. These adjustments are first normalized to result in an aggregate factor of 1.0 when applied to the projected 2018 membership.

B. Distribution and Administrative Costs:

Exhibit E-2, Column 3, reflects the adjustment for projected administrative costs, including sales, marketing, and any commission expense, and profit & risk. These are discussed above in the 'Non-Benefit Expenses and Profit & Risk' section, and exclude the Risk Adjustment User Fee, and Exchange User Fee, which are reflected in the Market-Adjusted Index Rate. These expense and profit assumptions do not vary by plan.

C. Provider Network, Delivery System, and Utilization Management:

The factors in Column 4 reflect the impact of differences in the network size, efficiency, and provider contract terms. We worked with our contracting area and other subject matter experts to review the impact of these differences and the expected impact on allowed claims.

D. Benefits in addition to EHBs:

The factors in Column 5 adjust for the impact of benefits in addition to EHBs.

These factors represent the added cost of covering the following benefits:

- One adult eye exam every 12 months

E. Catastrophic Plan Eligibility:
This filing does not include catastrophic plans.

Worksheet 2 of the URRT displays the Plan Adjusted Index Rates filed in 2016 for the experience period.

16. Calibration
A. Age Curve Calibration:
The age factors are based on the DC-specific age scale.

We project a premium-weighted average age factor for the 2018 membership using the prescribed age curve and the projected age distribution. The calibration factor is the reciprocal of this weighted average factor. The age that most closely corresponds to the premium weighted overall average age factor is the average age for the single risk pool.

Exhibit 11 shows this calculation.

B. Geographic Factor Calibration:
Projected area factors are shown in Exhibit 3. Unit cost trend studies were used to evaluate whether there were significant changes to network costs that would require changes from previously filed rating area factors. The geographic calibration factor is the reciprocal of the projected average area factor

C. Tobacco Factor Calibration
We are not applying a tobacco factor in our rating.

17. Consumer-Adjusted Premium Rate Development
Rates are determined using the prescribed member build-up approach. In the event that a family includes more than three child dependents under age 21, only the three oldest child dependents will be considered in determining the family's premium. Additional child dependents (non-billable members) will not be included in the rate calculation.

The premium for each billable member is calculated as:
Calibrated Plan Adjusted Index Rate * Age Factor * Area Factor * Trend Factor

The resulting rate is rounded to the nearest cent, and rates are then summed for all billable family members.

An example of a contract's premium determined by the member build-up calculation for a family of six, with more than three dependents under age 21, is shown in Exhibit 9.

18. Composite Premiums
Composite rates will not be offered to employers purchasing coverage through the public Marketplace in the District of Columbia.

19. AV Metal Values
The AV Metal Values on Worksheet 2 were based on the AV 2018 Calculator. As applicable, entries were modified to reflect the plan appropriately and/or adjustments were made for plan design features that could not be entered in the calculator per 45 CFR Part 156, §156.135. The accompanying certification discusses how the benefits were modified to fit the parameters and the development of any adjustments. The AV screen shots provide detail on the modified entries and adjustments to AV, as applicable.

20. AV Pricing Values

The AV Pricing Values are calculated as the ratio of the Plan Adjusted Index Rate to the Market Adjusted Index Rate. The adjustments reflected in the AV Pricing Values are discussed in Section 15. AV Pricing Values do not differ based on morbidity differences or benefit selection anticipated within the Single Risk Pool.

21. Membership Projections

Exhibit A summarizes the membership distribution by plan. Membership projections on Worksheet 2 are based on historical experience, enrollment in ACA-compliant plans through January 2017 and our expectations for future sales.

Terminated Plans and Products

Exhibit 10 provides a plan and product crosswalk from 2016 to 2018. The crosswalk includes the list of products that have experience in the single risk pool experience period, and products that were made available in 2017 and 2018.

Consistent with the URRT instructions, experience for non-single risk pool terminated products is reported in aggregate under the terminated product with the largest membership in the experience period.

22. Plan Type

All plans are consistent with the plan type indicated on Worksheet 2.

23. Warning Alerts

The Experience Period Incurred claims and Incurred Claims PMPM on Worksheet 2 adjust for the impacts of Reinsurance and Risk Adjustment. The Incurred Claims on Worksheet 1 are not adjusted for the impact of Reinsurance and Risk Adjustment. The warning alerts on rows 68 and 73 of Worksheet 2 result from the different treatment of Reinsurance and Risk Adjustment on the two worksheets.

24. Benefit Design

This filing includes one Bronze, two Silver, and three Gold plans.

Please refer to the corresponding policy forms for detailed benefit language. Exhibit A-2 provides the screenshots from the AV Calculator. All benefit and cost sharing parameters comply with District of Columbia benefit mandates and the requirements of PPACA, including preventive care benefits, deductible limits, and Actuarial Value requirements.

25. Marketing

Plans will be available outside of the public Marketplace. These plans may be marketed in a variety of means, including HHS Planfinder and our own website. In addition, members of our 2017 plans will be mailed a discontinuance or renewal letter, in accordance with CMS guidelines. Marketing and distribution approaches may change from time to time at management's discretion.

26. Underwriting

Aetna will verify applicant eligibility for these plans based on any applicable age or geographic limitations.

27. Renewability

These policies are guaranteed renewable as required under §2703 of the Public Health Service Act.

28. Company Financial Condition

As of December 31, 2016, the capital and surplus held by Aetna Health Inc. Of Pennsylvania was approximately $458 Million. This amount is disclosed in page 3, line 33 of the Company's statutory financial statement dated December 31, 2016. The Company issues commercial and Medicare Advantage coverage in various states for multiple business segments, including to large employer, small employer, and individual purchasers.

Reliance

While I have reviewed the reasonableness of the assumptions and data in support of both the preparation of the Part I Unified Rate Review Template and the rate development applicable to the products discussed in this filing, I relied on the expertise of other Aetna employees, along with work products produced at their direction, for the following items:

- Experience Period MLR Rebates
- Risk Adjustment Transfer
- Actuarial Value, Modifications, and Benefit Relativities
- Supplemental EHB Pricing
- Population Risk Morbidity
- Medical Cost and Utilization Trend
- Rx Cost and Utilization Trend
- Components of Retention/Administrative Fees
- Value of Network Arrangements
- Experience Period Data – Small Group

Certification

While this memorandum discusses both our development of rates for these products and the completion of the Part I Unified Rate Review Template (URRT), the Part I URRT does not demonstrate the process used by Aetna to develop the rates. Rather, it represents information required by Federal regulation to be provided in support of the review of rate increases, for certification of qualified health plans for Federally-facilitated marketplaces, and for certification that the index rate is developed in accordance with Federal regulation, is used consistently, and is only adjusted by the allowable modifiers. The information provided above is intended to comply with these requirements.

I, Erica A. Mitchell, am a Fellow of the Society of Actuaries, a member of the American Academy of Actuaries, and am qualified in the area of health insurance. I hereby certify that to the best of my knowledge and judgment:

1. This rate filing is in compliance with the applicable laws and regulations of District of Columbia, the requirements under federal law and regulation, and all applicable Actuarial Standards of Practice, including but not limited to:

    a. ASOP No. 5, Incurred Health and Disability Claims
    b. ASOP No. 8, Regulatory Filings for Health Benefits, Accident and Health Insurance, and Entities Providing Health
    c. ASOP No. 12, Risk Classification
    d. ASOP No. 23, Data Quality
    e. ASOP No. 25, Credibility Procedures Applicable to Accident and Health, Group Term Life, and Property/Casualty Coverages

f. ASOP No. 26, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans
g. ASOP No. 41, Actuarial Communications
h. ASOP No. 50, Determining Minimum Value and Actuarial Value under the Affordable Care Act

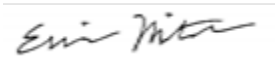
2. The Projected Index Rate is:
    a. In compliance with all applicable State and Federal Statutes and Regulations (45 CFR 156.80(d)(1) and 147.102),
    b. Developed in compliance with the applicable Actuarial Standards of Practice,
    c. Reasonable in relation to the benefits provided and the population anticipated to be covered,
    d. Neither excessive, deficient, nor unfairly discriminatory.

3. The Index Rate and only the allowable modifiers as described in 45 CFR 156.80(d)(1) and 45 CFR 156.80(d)(2) were used to generate plan-level rates.

4. The percent of total premium that represents essential health benefits included in Worksheet 2, Sections III and IV were calculated in accordance with actuarial standards of practice.

5. The geographic rating factors reflect only differences in the costs of delivery (which include unit costs and provider practice pattern differences) and do not include differences for population morbidity by geographic area.

6. The AV Calculator was used to determine the AV Metal Values shown in Worksheet 2 of the Part I Unified Rate Review Template for all plans. Adjustments made to reflect benefit features not handled by the AV Calculator are discussed in the attached certification required by 45 CFR Part 156, §156.135.



May 1, 2017

Erica A. Mitchell, FSA, MAAA
Aetna Health Inc.

Date

Aetna Health Inc.
D.C. Small Group
HMO Products

Summary

Aetna Health Inc. has filed 2018 premium rates for small group plans in the District of Columbia.

Who is affected?

Policies that renew in 2018 in the following products will be affected:

Product Name	# Current Members	Range of Increases
Aetna Health Inc	451	8.4% - 15.3%, 9.4% Average

2018 Premium rates for members in the above products will increase by 8.4% - 15.3% in plans listed for Aetna Health Maintenance Organization. Increases are determined by the member's plan and rating area in which they are located.

Why We Need to Increase Premiums

In 2016, Aetna's financial results were worse than the level required for long-term stability in the Small Group market.

Medical costs are going up and we are changing our rates to reflect this increase. We expect medical costs to go up 11.2%. Medical costs go up mainly for two reasons – providers raise their prices and members get more medical care.

For Small Employers in the District of Columbia, some examples of increasing medical costs we have experienced in the last 12 months include:

- The cost for an inpatient hospital admission has increased 6.0%
- Use for pharmacy prescriptions have gone up 7.7%
- Use for physician service has increased 4.4%

What Else Affects Our Request to Increase Premiums

Changes to cost-sharing for some plans were made to comply with the actuarial value requirements and/or make our plans more attractive to consumers. This increases costs by up to 2.5%.

Our estimate of average population health and the expected risk adjustment transfers for Affordable Care Act (ACA) products have changed to reflect new data on market average premiums and population health. Small groups purchasing insurance in the market place are sicker than we initially anticipated. Population risk is also affected by the movement of business between the ACA market and other options as well as among other carriers in the marketplace. These changes are expected to increase costs by 2.9%.

Will Premiums for All Individuals Increase 9.4%?

No, Increases differ by plan. Some premiums will increase by less than average or even go down. Others will increase by more than the average.

The exact rate change will depend on what benefit plan the individual chooses, when the member's group contract renews, the age and family size and age for enrolling employees, and employer contributions.

How does this request align to Minimum Loss Ratio Requirements (MLR)?

Non-claim costs are also going up. The Federal Health Insurers Fee has been reinstated after a reprieve in 2017. Some costs, such as operating our IT systems, complying with reporting requirements, and managing our business remain fixed, and are now being spread across fewer members, resulting in higher administrative costs. Aetna will only charge members for the portion of administrative costs that enable plans to still meet the 80% Minimum Loss Ratio requirement.

These rates are expected to produce an MLR equal to or above the 80% requirement for small group business. Under the ACA, at least 80% of the premiums collected by health plans are expected to pay for medical care and activities that improve health care quality for members. If the actual MLR turns out to be less than 80%, rebates will be issued to members in accordance with the law.

Aetna makes significant investments that benefit our members that the government does not allow us to use in this calculation. These investments include customer service, health quality activities like disease management programs, and the development of new information technologies.

What is Aetna doing to keep premiums affordable?

Aetna is taking a number of steps to keep our products as affordable as possible and to address the underlying cost of health care. These actions include:

- Developing new agreements, arrangements, and partnerships with health care providers that base provider compensation on the quality of care and not the quantity of services.
- Creating medical management programs that address potential health issues for members earlier, improving health outcomes and reducing the need for high-cost health care services.
- Working to reduce the ability of out-of-network providers to collect unreasonably excessive payments for services they provide.

Aetna is dedicated to increasing transparency within the health care system and helping members best utilize the plans that they have. Members can access Aetna Navigator, a secure member website, which allows them to research their specific plan benefits, health care providers in a given area, and in some locations, the cost of certain health care services. Additionally, Aetna's DocFind directory helps members locate in-network doctors and hospitals to save money on their care. The Aetna Navigator streamlined mobile app is also available to allow members to take their care on the go.

Also, Aetna's Plan for Your Health website aims to educate all consumers on how to take advantage of their health care benefits.

980 Jolly Road
Mail Code U12S
Blue Bell, PA 19422
(215)-775-3837
Fax: (215)-775-6441

May 1, 2017

Mr. Efren Tanheco
Supervising Actuary
District of Columbia Department of Insurance & Securities Regulation
810 First Street NE, 6th Floor
Washington, DC 20002

Subject: Aetna Health, Inc. - NAIC Number 95109
Small Group Premium Rate Filing – DC On Exchange
Effective dates January 1, 2018 – December 31, 2018

Dear Mr. Tanheco:

I am writing to request approval of the attached Rate Filing for plans offered to Small Groups by Aetna Health, Inc. sold on the DC Exchange. This filing is for effective dates January 1, 2018 – December 31, 2018. This filing contains the benefit plans and rating methodology. The average rate revision proposed is an increase of 9.4%.

The requested rates have been developed incorporating consideration of the market changes and rating requirements taking effect in the Small Group Market and conforms to the benefit plan provisions required by the Patient Protection and Affordable Care Act (P.L. 111-148) of 2010. Additionally, these health benefit plans conform to each respective tier of coverage, defined as Bronze, Silver, and Gold.

This filing is for Aetna's Small Group HMO Medical Expense coverage.

The following supporting documentation is also included:

1) An Actuarial Certification
2) An Actuarial Memorandum including supporting exhibits and documentation

The forms filing has been submitted under separate cover and the SERFF Filing ID # is AETN-130955797.

The purpose of this rate filing is to comply with regulatory rate filing requirements. This filing is not intended to be used for other purposes. If you need additional information, please contact me by telephone at (860) 273-3188, or via e-mail at AndersonD1@Aetna.com.

Sincerely,

Diane S. Anderson

Diane S. Anderson

Certificate Form Names and Numbers

Form Name	*Form Number*
HI DC SG HHIXCOC V002	HI SG HCOC 2018 02-HIX
HI DC HGrpAg V003	HI SG HGrpAg 03

Schedule Form Names and Numbers

Form Name	*Form Number*
HI DC SG-HIXSOB-14038682 V002	HI SG-SOB-14038682 02-HIX
HI DC SG-HIXSOB-14038683 V002	HI SG-SOB-14038683 02-HIX
HI DC SG-HIXSOB-14038684 V002	HI SG-SOB-14038684 02-HIX
HI DC SG-HIXSOB-14038685 V002	HI SG-SOB-14038685 02-HIX
HI DC SG-HIXSOB-14038686 V002	HI SG-SOB-14038686 02-HIX
HI DC SG-HIXSOB-14038687 V002	HI SG-SOB-14038687 02-HIX

Unified Rate Review v4.2

Company Legal Name: **Aetna Health Inc. (a PA corp.)** State: **DC**
HIOS Issuer ID: **73987** Market: **Small Group**
Effective Date of Rate Change(s): **1/1/2018**

Market Level Calculations (Same for all Plans)

Section I: Experience period data

Experience Period: 1/1/2016 to 12/31/2016

	Experience Period Aggregate Amount	PMPM	% of Prem
Premiums (net of MLR Rebate) in Experience Period:	$2,215,754	$405.59	100.00%
Incurred Claims in Experience Period	$1,588,364	290.75	71.69%
Allowed Claims:	$1,917,829	351.06	86.55%
Index Rate of Experience Period		$351.06	
Experience Period Member Months	5,463		

Section II: Allowed Claims, PMPM basis

Projection Period: 1/1/2018 to 12/31/2018 Mid-point to Mid-point, Experience to Projection: 24 months

	Experience Period on Actual Experience Allowed				Adj't. from Experience to Projection Period		Annualized Trend Factors		Projections, before credibility Adjustment			Credibility Manual				
Benefit Category	**Utilization Description**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Pop'l risk Morbidity**	**Other**	**Cost**	**Util**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**	**Utilization per 1,000**	**Average Cost/Service**	**PMPM**		
Inpatient Hospital	Days	74.32	$3,724.30	$23.07	1.029	0.965	1.060	1.024	80.10	$4,035.62	$26.94	231.78	$3,906.71	$75.46		
Outpatient Hospital	Visits	574.30	1,619.03	77.48	1.029	0.965	1.049	1.064	668.25	1,719.97	95.78	475.70	1,636.42	64.87		
Professional	Visits	8,353.07	172.69	120.21	1.029	0.965	1.018	1.044	9,357.54	172.63	134.61	6806.60	200.02	113.45		
Other Medical	Visits	4,261.35	187.51	66.59	1.029	0.965	1.049	1.064	4,958.45	199.20	82.31	4094.16	222.18	75.80		
Capitation	Benefit Period	0.00	0.00	0.00	1.029	0.965	1.000	1.000	0.00	0.00	0.00	0.00	0.00	0.00		
Prescription Drug	Prescriptions	6,764.82	113.02	63.71	1.029	0.977	1.077	1.040	7,522.79	128.03	80.26	8137.66	123.90	84.02		
Total				$351.06							$419.91			$413.61		

Section III: Projected Experience:

			After Credibility	Projected Period Totals
Projected Allowed Claims PMPM (w/applied credibility if applicable)	0.00%	100.00%	$413.61	$648,122
Paid to Allowed Average Factor in Projection Period			0.796	
Projected Incurred Claims, before ACA rein & Risk Adj't, PMPM			$329.14	$515,757
Projected Risk Adjustments PMPM			-19.76	(30,960)
Projected Incurred Claims, before reinsurance recoveries, net of rein prem, PMPM			$348.89	$546,717
Projected ACA reinsurance recoveries, net of rein prem, PMPM			0.00	0
Projected Incurred Claims			$348.89	$546,717
Administrative Expense Load		10.98%	50.71	79,458
Profit & Risk Load		3.90%	18.01	28,216
Taxes & Fees		9.55%	44.10	69,099
Single Risk Pool Gross Premium Avg. Rate, PMPM			$461.70	$723,490
Index Rate for Projection Period			$421.67	
% increase over Experience Period			13.83%	
% Increase, annualized:			6.69%	
Projected Member Months				1,567

Product-Plan Data Collection

Company Legal Name: **Aetna Health Inc. (a PA corp.)** State: **DC**
HIOS Issuer ID: **73987** Market: **Small Group**
Effective Date of Rate Change(s): **1/1/2018**

Product/Plan Level Calculations

Section I: General Product and Plan Information

Product		Aetna Health Maintenance Organization																		
Product ID:		73987DC004																		
Metal:		Silver	Bronze	Silver	Gold	Gold	Gold	Gold	Gold	Silver	Bronze	Gold	Gold	Gold	Gold	Bronze	Silver	Silver	Gold
AV Metal Value		0.710	0.617	0.689	0.817	0.782	0.784	0.782	0.792	0.716	0.616	0.782	0.792	0.785	0.781	0.617	0.716	0.714	0.784
AV Pricing Value		0.841	0.725	0.915	1.112	1.143	1.111	0.010	0.010	0.010	0.010	0.010	0.010	0.010	0.010	0.010	0.010	0.010	0.010
Plan Category		New	Renewing	Renewing	Renewing	Renewing	Renewing	Terminated	Terminated	Terminated	Terminated	Terminated	Terminated	Terminated	Terminated	Terminated	Terminated	Terminated	Terminated
Plan Type:		HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
Plan Name		DC Silver HMO 4500 80	DC Bronze HMO 5000 80 HSA E	DC Silver HMO 3000 100 HSA E	DC Gold HMO 70	DC Gold HMO 500 90	DC Gold HMO 1600 100 HSA T	DC Gold HNOnly 2000 70	DC Gold HNOnly SJ 1500 100	DC Silver HNOnly SJ 2500 100	DC Bronze HNOnly 5400 100 HSA Emb RE	DC Gold HNOnly 2000 70 RE	DC Gold HNOnly SJ 1500 100 RE	DC Gold HNOnly 70 RE	DC Gold HNOnly 500 90 RE	DC Bronze HNOnly 5000 80 HSA Emb RE	DC Silver HNOnly SJ 2500 100 RE	DC Silver HNOnly 2500 90 HSA RE	DC Gold HNOnly 1700 100 HSA RE
Plan ID (Standard Component ID):		73987DC0040057	73987DC0040056	73987DC0040029	73987DC0040017	73987DC0040021	73987DC0040046	73987DC0040005	73987DC0040034	73987DC0040035	73987DC0040036	73987DC0040037	73987DC0040040	73987DC0040041	73987DC0040042	73987DC0040043	73987DC0040044	73987DC0040045	73987DC0040047
Exchange Plan?		Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No	No	No	No	No	No	No
Historical Rate Increase - Calendar Year - 2		1.32%																	
Historical Rate Increase - Calendar Year - 1		2.67%																	
Historical Rate Increase - Calendar Year 0		9.10%																	
Effective Date of Proposed Rates		1/1/2018	1/1/2018	1/1/2018	1/1/2018	1/1/2018	1/1/2018	1/1/2018	1/1/2018	1/1/2018	1/1/2018	1/1/2018	1/1/2018	1/1/2018	1/1/2018	1/1/2018	1/1/2018	1/1/2018	1/1/2018
Rate Change % (over prior filing)		0.00%	3.26%	3.73%	1.67%	1.31%	7.77%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Cum'tive Rate Change % (over 12 mos prior)		0.00%	10.50%	11.00%	8.80%	8.41%	15.33%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Proj'd Per Rate Change % (over Exper. Period)		#DIV/0!	14.34%	18.72%	18.46%	16.94%	15.45%	-100.00%	-100.00%	-100.00%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Product Rate Increase %		9.38%																	

Section II: Components of Premium Increase (PMPM Dollar Amount above Current Average Rate PMPM)

Plan ID (Standard Component ID):	Total	73987DC0040057	73987DC0040056	73987DC0040029	73987DC0040017	73987DC0040021	73987DC0040046	73987DC0040005	73987DC0040034	73987DC0040035	73987DC0040036	73987DC0040037	73987DC0040040	73987DC0040041	73987DC0040042	73987DC0040043	73987DC0040044	73987DC0040045	73987DC0040047
Inpatient	$1.15	$0.97	$1.46	$1.68	$1.36	$1.28	$2.70	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Outpatient	$3.87	$3.24	$4.91	$5.63	$4.57	$4.31	$9.07	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Professional	$6.00	$5.03	$7.61	$8.74	$7.09	$6.69	$14.07	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Prescription Drug	$3.18	$2.67	$4.04	$4.63	$3.76	$3.55	$7.46	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Other	$3.29	$2.76	$4.17	$4.79	$3.89	$3.67	$7.71	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Capitation	$0.03	$0.03	$0.04	$0.05	$0.04	$0.04	$0.08	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Administration	-$1.41	-$1.71	-$1.71	-$1.71	-$1.71	-$1.71	-$1.71	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Taxes & Fees	-$11.75	-$14.20	-$14.20	-$14.20	-$14.20	-$14.20	-$14.20	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Risk & Profit Charge	$1.00	$1.21	$1.21	$1.21	$1.21	$1.21	$1.21	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Rate Increase	$5.37	$0.00	$7.53	$10.82	$6.01	$4.84	$26.39	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Member Cost Share Increase	$37.87	$45.77	$45.77	$45.77	$45.77	$45.77	$45.77	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Average Current Rate PMPM	$320.91	$0.00	$231.30	$290.32	$360.12	$371.36	$339.35	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Projected Member Months	1,567	81	186	195	397	625	83	0	0	0	0	0	0	0	0	0	0	0	0

Section III: Experience Period Information

	Plan ID (Standard Component ID):	Total	73987DC0040057	73987DC0040056	73987DC0040029	73987DC0040017	73987DC0040021	73987DC0040046	73987DC0040005	73987DC0040034	73987DC0040035	73987DC0040036	73987DC0040037	73987DC0040040	73987DC0040041	73987DC0040042	73987DC0040043	73987DC0040044	73987DC0040045	73987DC0040047
Premium Information	Plan Adjusted Index Rate	$405.01	$0.00	$287.32	$348.93	$425.16	$442.56	$435.74	$406.44	$405.94	$362.48	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Member Months	5,412	0	586	543	1,208	2,087	54	653	139	142	0	0	0	0	0	0	0	0	0
	Total Premium (TP)	$2,184,288	$0	$185,620	$247,946	$447,638	$917,876	$18,921	$266,618	$41,161	$58,508	$0	$0	$0	$0	$0	$0	$0	$0	$0
	EHB Percent of TP, [see instructions]	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%
	state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Other benefits portion of TP	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%
Claims Information	Total Allowed Claims (TAC)	$1,880,788	$0	$46,267	$100,265	$382,227	$1,124,500	$17,153	$161,988	$26,325	$22,063	$0	$0	$0	$0	$0	$0	$0	$0	$0
	EHB Percent of TAC, [see instructions]	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%
	state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Other benefits portion of TAC	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%
	Allowed Claims which are not the issuer's obligation:	-$195,711	$0	-$99,621	-$92,811	-$29,285	$103,606	-$5,531	-$38,007	-$12,765	-$21,297	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Portion of above payable by HHS's funds on behalf of insured person, in dollars	$0	$0	$0	$0	$0	$0	$0												
	Portion of above payable by HHS on behalf of insured person, as %	0.00%	#DIV/0!	0.00%	0.00%	0.00%	0.00%	0.00%												
	Total Incurred claims, payable with issuer funds	$2,076,499	$0	$145,888	$193,075	$411,512	$1,020,894	$22,685	$199,995	$39,090	$43,361	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Amt of Rein	-$12,177.00	$0.00	-$1,318.50	-$1,221.75	-$2,718.00	-$4,695.75	-$121.50	-$1,469.25	-$312.75	-$319.50	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Net Amt of Risk Adj	-$520,356.43	$0.00	-$128,128.49	-$141,588.77	-$88,267.89	-$30,399.08	-$10,871.60	-$65,287.91	-$20,974.96	-$34,837.73	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Incurred Claims PMPM	$383.68	#DIV/0!	$248.96	$355.57	$340.66	$489.17	$420.09	$306.27	$281.22	$305.36	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
	Allowed Claims PMPM	$347.52	#DIV/0!	$78.95	$184.65	$316.41	$538.81	$317.66	$248.07	$189.39	$155.38	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
	EHB portion of Allowed Claims, PMPM	$347.38	#DIV/0!	$78.92	$184.58	$316.29	$538.60	$317.53	$247.97	$189.31	$155.31	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Section IV: Projected (12 months following effective date)

	Plan ID (Standard Component ID):	Total	73987DC0040057	73987DC0040056	73987DC0040029	73987DC0040017	73987DC0040021	73987DC0040046	73987DC0040005	73987DC0040034	73987DC0040035	73987DC0040036	73987DC0040037	73987DC0040040	73987DC0040041	73987DC0040042	73987DC0040043	73987DC0040044	73987DC0040045	73987DC0040047
Premium Information	Plan Adjusted Index Rate	$470.89	$380.95	$328.53	$414.24	$503.65	$517.51	$503.08	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
	Member Months	1,567	81	186	195	397	625	83	-	-	-	-	-	-	-	-	-	-	-	-
	Total Premium (TP)	$723,495	$30,255	$59,914	$79,201	$196,048	$317,134	$40,941	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	EHB Percent of TP, [see instructions]	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%
	state mandated benefits portion of TP that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Other benefits portion of TP	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%
Claims Information	Total Allowed Claims (TAC)	$648,126	$30,463	$67,520	$77,526	$169,291	$267,758	$35,568	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	EHB Percent of TAC, [see instructions]	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%	99.96%
	state mandated benefits portion of TAC that are other than EHB	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
	Other benefits portion of TAC	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%	0.04%
	Allowed Claims which are not the issuer's obligation	$105,242	$7,457	$21,459	$17,636	$22,725	$31,006	$4,959	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Portion of above payable by HHS's funds on behalf of insured person, in dollars	$0	$0	$0	$0	$0	$0	$0												
	Portion of above payable by HHS on behalf of insured person, as %	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%												
	Total Incurred claims, payable with issuer funds	$542,884	$23,006	$46,061	$59,890	$146,566	$236,752	$30,610	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Amt of Rein	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Net Amt of Risk Adj	-$30,960	-$1,600	-$3,675	-$3,853	-$7,844	-$12,349	-$1,640	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Incurred Claims PMPM	$346.45	$284.02	$247.64	$307.13	$369.18	$378.80	$368.79	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
	Allowed Claims PMPM	$413.61	$376.09	$363.01	$397.57	$426.43	$428.41	$428.53	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
	EHB portion of Allowed Claims, PMPM	$413.44	$375.94	$362.86	$397.41	$426.25	$428.24	$428.36	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Rate Filing Justification Part II (Plain Language Summary)

Pursuant to 45 CFR 154.215, health insurance issuers are required to file Rate Filing Justifications. Part II of the Rate Filing Justification for rate increases and new submissions must contain a written description that includes a simple and brief narrative describing the data and assumptions that were used to develop the proposed rates. The Part II template below must be filled out and uploaded as an Adobe PDF file under the Consumer Disclosure Form section of the Supporting Documentation tab.

Name of Company	Aetna Health, Inc.
SERFF tracking number	AETN-131001834
Submission Date	May 1, 2017
Product Name	DC AHI HMO SG 2018
Market Type	○ Individual ◉ Small Group
Rate Filing Type	◉ Rate Increase ○ New Filing

Scope and Range of the Increase:

The 9.4 % increase is requested because:

Rates are updated to reflect the impact of medical trend, revisions to our assumptions about population morbidity and projected population, changes in cost sharing levels to ensure compliance with Actuarial Value requirements, and changes in provider networks and contracts.

This filing will impact:

# of policyholder's 290 # of covered lives 410

The average, minimum and maximum rate changes increases are:

- Average Rate Change: The average premium change, by percentage, across all policy holders if the filing is approved 9.4 %
- Minimum Rate Change: The smallest premium increase (or largest decrease), by percentage, that any one policy holder would experience if the filing is approved 7.4 %
- Maximum Rate Change: The largest premium increase, by percentage, that any one policy holder would experience if the filing is approved 18.1%

Individuals within the group may vary from the aggregate of the above increase components as a result of:

the benefit plan the individual chooses, when the member's group contract renews, the age and family size and age for enrolling employees and employer contributions.

Financial Experience of Product

The overall financial experience of the product includes:

The 2016 experience generated by the plans offered under this product produced a loss ratio that was favorable to the target loss ratio (before risk adjustment), and unfavorable after risk adjustment. Due to the low volume of members that have enrolled in these plans the 2016 experience is not credible.

The rate increase will affect the projected financial experience of the product by:

The rate revision is not expected to impact the profitability of the product. That is, the target profit margin is unchanged

Components of Increase

The request is made up of the following components:

Trend Increases – 101. % of the 9.4 % total filed increase

1. Medical Utilization Changes –Defined as the increase in total plan claim costs not attributable to changes in the unit cost of underlying services, or renegotiation of provider contracts. Examples include changes in the mix of services utilized, or an increase/decrease in the frequency of service utilization.

   This component is 49.8 % of the 9.4 % total filed increase.

2. Medical Price Changes – Defined as the increase in total plan claim costs attributable to changes in the unit cost of underlying services, or renegotiation of provider contracts.

   This component is 51.6 % of the 9.4 % total filed increase.

Other Increases – -1.4 % of the 9.4 % total filed increase

1. Medical Benefit Changes Required by Law – Defined as any new mandated plan benefit changes, as mandated by either State or Federal Regulation.

   This component is -7.4 % of the 9.4 % total filed increase.

2. Medical Benefit Changes Not Required by Law – Defined as changes in plan benefit design made by the company, which are not required by either State or Federal Regulation.

   This component is 0 % of the 9.4 % total filed increase.

3. Changes to Administration Costs – Defined as increases in the costs of providing insurance coverage. Examples include claims payment expenses, distribution costs, taxes, and general business expenses such as rent, salaries, and overhead.

   This component is 13.8 % of the 9.4 % total filed increase.

4. Changes to Profit Margin – Defined as increases to company surplus or changes as an additional margin to cover the risk of the company.

   This component is 0.0 % of the 9.4 % total filed increase.

5. Other – Defined as:

   Changes in commission, benefit slope, risk adjustment, provider contracting, experience and population risk.

   This component is -7.8 % of the 9.4 % total filed increase.

Aetna Health Inc. (a PA corp.)
HIOS ISSUER ID: 73987

Exhibit E-2
Calculation of Plan Adjusted Index Rates and Calibrated Plan Adjusted Index Rates

				(1)	(2)	(3)	(4)	(5)	(6)	(7) = Product (Columns 1-6)	(8)	(9)	(10)	(11)	(12) = Product (Columns 8-11)	(13) = (7) x (12)	(14) = (7) / (1)
HIOS ID	**Plan Name**	**Metal Tier**	**Membership**	**Market Adjusted Index Rate**	**AV & Cost Sharing**	**Distribution & Admin**	**Network & UM**	**Benefits in addition to EHBs**	**Impact of Eligibility (CAT)**	**Plan Adjusted Index Rate**	**Tobacco Calibration Factor**	**Age Calibration Factor**	**Geography Calibration Factor**	**Trend Factor**	**Calibration Factor**	**Calibrated Plan Adjusted Index Rate**	**AV Pricing Value**
73987DC0040017	DC Gold HMO 70%	Gold	25.34%	$452.91	0.851	1.306	1.000	1.000	1.000	503.65	1.000	0.955	1.000	0.980	0.936	471.55	1.112
73987DC0040021	DC Gold HMO 500 90%	Gold	39.89%	$452.91	0.875	1.306	1.000	1.000	1.000	517.51	1.000	0.955	1.000	0.980	0.936	484.52	1.143
73987DC0040029	DC Silver HMO 3000 100% HSA E	Silver	12.44%	$452.91	0.700	1.306	1.000	1.000	1.000	414.24	1.000	0.955	1.000	0.980	0.936	387.84	0.915
73987DC0040046	DC Gold HMO 1600 100% HSA T	Gold	5.30%	$452.91	0.850	1.306	1.000	1.000	1.000	503.08	1.000	0.955	1.000	0.980	0.936	471.02	1.111
73987DC0040056	DC Bronze HMO 5000 80% HSA E	Bronze	11.87%	$452.91	0.555	1.306	1.000	1.000	1.000	328.53	1.000	0.955	1.000	0.980	0.936	307.59	0.725
73987DC0040057	DC Silver HMO 4500 80%	Silver	5.17%	$452.91	0.644	1.306	1.000	1.000	1.000	380.95	1.000	0.955	1.000	0.980	0.936	356.67	0.841

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Exhibit 1
2018 Rate Increases by Product

Product	Average Rate Increase	Minimum Rate Increase	Maximum Rate Increase
Aetna Health Maintenance Organization	9.38%	8.41%	15.33%

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Exhibit 2
Claim Impact due to Demographic Changes

	Experience Period Distribution		Experience Demographic Factor		Projected Period Distribution		Projection Demographic Factor	
Age	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**
0	0.35%	0.38%	1.050	0.939	0.64%	0.53%	1.050	0.939
1	0.16%	0.16%	1.050	0.939	0.58%	0.54%	1.050	0.939
2	0.16%	0.57%	0.601	0.596	0.56%	0.55%	0.601	0.596
3	0.11%	0.73%	0.601	0.596	0.58%	0.55%	0.601	0.596
4	0.64%	0.18%	0.601	0.596	0.64%	0.57%	0.601	0.596
5	0.68%	0.53%	0.570	0.565	0.59%	0.55%	0.570	0.565
6	0.35%	1.08%	0.570	0.565	0.63%	0.60%	0.570	0.565
7	0.31%	0.57%	0.570	0.565	0.65%	0.62%	0.570	0.565
8	0.20%	0.27%	0.570	0.565	0.68%	0.64%	0.570	0.565
9	0.35%	0.04%	0.570	0.565	0.68%	0.69%	0.570	0.565
10	0.05%	0.35%	0.578	0.565	0.70%	0.71%	0.578	0.565
11	0.11%	0.02%	0.578	0.565	0.66%	0.64%	0.578	0.565
12	0.59%	0.57%	0.578	0.565	0.69%	0.65%	0.578	0.565
13	0.11%	0.38%	0.578	0.565	0.70%	0.69%	0.578	0.565
14	0.26%	0.37%	0.578	0.565	0.75%	0.66%	0.578	0.565
1	0.38%	0.33%	0.606	0.615	0.74%	0.72%	0.606	0.615
16	0.29%	0.37%	0.606	0.615	0.74%	0.66%	0.606	0.615
17	0.37%	0.00%	0.606	0.615	0.67%	0.66%	0.606	0.615
18	0.35%	0.22%	0.606	0.615	0.67%	0.72%	0.606	0.615
19	0.35%	0.42%	0.606	0.615	0.77%	0.68%	0.606	0.615
20	0.37%	0.49%	0.451	0.741	0.75%	0.62%	0.451	0.741
21	0.40%	0.70%	0.451	0.741	0.78%	0.64%	0.451	0.741
22	0.55%	0.29%	0.451	0.741	0.69%	0.68%	0.451	0.741
23	0.59%	1.01%	0.451	0.741	0.77%	0.76%	0.451	0.741
24	1.21%	1.56%	0.451	0.741	0.75%	0.75%	0.451	0.741
25	1.43%	1.13%	0.460	1.106	0.83%	0.73%	0.460	1.106
26	2.82%	1.15%	0.460	1.106	0.85%	0.85%	0.460	1.106
27	2.34%	1.45%	0.460	1.106	0.80%	0.83%	0.460	1.106
28	2.05%	1.81%	0.460	1.106	0.83%	0.81%	0.460	1.106
29	2.54%	0.75%	0.460	1.106	0.87%	0.90%	0.460	1.106
30	1.70%	0.46%	0.519	1.197	0.98%	0.85%	0.519	1.197
31	1.79%	1.10%	0.519	1.197	1.02%	0.94%	0.519	1.197
32	1.68%	0.93%	0.519	1.197	1.10%	0.85%	0.519	1.197
33	1.46%	1.54%	0.519	1.197	1.07%	0.90%	0.519	1.197
34	1.17%	0.70%	0.519	1.197	1.05%	0.99%	0.519	1.197
35	1.19%	0.46%	0.630	1.197	1.12%	0.95%	0.630	1.197
36	1.57%	0.71%	0.630	1.197	1.12%	0.89%	0.630	1.197
37	1.54%	1.37%	0.630	1.197	0.89%	0.81%	0.630	1.197
38	1.45%	1.03%	0.630	1.197	0.90%	0.79%	0.630	1.197
39	1.24%	0.53%	0.630	1.197	0.93%	0.81%	0.630	1.197
40	1.06%	1.03%	0.790	1.197	0.95%	0.77%	0.790	1.197
41	0.93%	0.59%	0.790	1.197	0.90%	0.80%	0.790	1.197
42	0.59%	0.38%	0.790	1.197	0.83%	0.79%	0.790	1.197
43	0.55%	0.60%	0.790	1.197	1.00%	0.84%	0.790	1.197
44	1.30%	0.77%	0.790	1.197	1.03%	0.86%	0.790	1.197
45	0.35%	0.46%	1.000	1.269	1.00%	0.86%	1.000	1.269
46	0.00%	0.44%	1.000	1.269	0.98%	0.84%	1.000	1.269
47	0.71%	0.55%	1.000	1.269	0.95%	0.86%	1.000	1.269
48	1.04%	0.48%	1.000	1.269	1.00%	0.74%	1.000	1.269
49	0.97%	0.60%	1.000	1.269	0.99%	0.72%	1.000	1.269
50	0.38%	0.22%	1.370	1.460	0.97%	0.82%	1.370	1.460
51	0.29%	0.38%	1.370	1.460	0.93%	0.86%	1.370	1.460
52	0.71%	1.68%	1.370	1.460	1.15%	0.82%	1.370	1.460
53	0.62%	1.46%	1.370	1.460	1.09%	0.90%	1.370	1.460
54	1.10%	1.19%	1.370	1.460	0.92%	0.75%	1.370	1.460
55	0.88%	0.62%	1.757	1.745	0.95%	0.71%	1.757	1.745
56	0.84%	0.59%	1.757	1.745	0.87%	0.69%	1.757	1.745
57	0.31%	0.97%	1.757	1.745	0.80%	0.61%	1.757	1.745
58	0.60%	0.84%	1.757	1.745	0.68%	0.54%	1.757	1.745
59	0.92%	0.73%	1.757	1.745	0.71%	0.56%	1.757	1.745
60	0.44%	0.66%	2.218	2.128	0.64%	0.53%	2.218	2.128
61	0.59%	0.46%	2.218	2.128	0.52%	0.42%	2.218	2.128
62	0.95%	0.46%	2.218	2.128	0.47%	0.39%	2.218	2.128
63	0.51%	0.86%	2.218	2.128	0.44%	0.35%	2.218	2.128
64	0.59%	0.73%	2.218	2.128	0.38%	0.30%	2.218	2.128
65+	1.57%	1.45%	3.200	2.700	0.66%	0.47%	3.200	2.700

Experience Period Demographic Factor	1.0456

Note:
Experience Period Demographic Factor computed as the weighted average of gender specific Demographic Factor by current population distribution.

Projected Demographic Factor	1.0033

Note:
Projected Demographic Factor computed as the weighted average of gender specific Demographic Factor by projected population distribution.

Demographic Change	0.9596

Note:
Claim Impact due to Demographic Changes computed as the ratio of the Projected Demographic Factor over the Experience Period Demographic Factor.

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Exhibit 3
Projected Membership Distribution by County

Rating Area	Counties	Experience Period Membership	Experience Period Area Factor	Projected Membership	Projected Area Factor
1	District of Columbia	100%	1.000	100%	1.000

Average Experience Period Area Factor	1.0000

Note:
Average Experience Period Area Factor computed as the weighted average of Experience Period Area Factors by experience period membership distribution.

Average Projected Area Factor	1.0000

Note:
Projected Area Factor computed as the weighted average of Projection Period Area Factors by projected membership distribution.

Area Shift Factor	1.0000

Note:
Area Shift Factor computed as the ratio of the Projected Membership by Area over the Experience Membership by Area Factor represents:
The impact due to the shift of the population distribution across areas.

Area Factor Change	1.0000

Note:
Area Factor Change computed as the ratio of the Projected Area Factor over the Experience Area Factor both using projected membership Factor represents:
The impact due to cost relativity changes, including changes to provider networks and contracts, from the experience period to the rating period.

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Exhibit 4
Projected Membership and Paid to Allowed by Metal Tier

Metallic Tier	Projected Membership	Projected Paid to Allowed Ratio
Platinum	0	N/A
Gold	1,105	84%
Silver	276	73%
Bronze	186	64%
Catastrophic	0	N/A
Total	1,567	80%

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Exhibit 5
Retention as a Percent of Premium and PMPM

Retention Components	% of Premium	PMPM
Administrative Expense Load	10.98%	$50.71
Profit & Risk Load	3.90%	$18.01
Premium Tax	3.26%	$15.05
User Exchange Fee	1.00%	$4.62
State Based Exchange Fee	0.00%	$0.00
HIF	3.15%	$14.54
PCORI	0.04%	$0.19
Federal Income Tax	2.10%	$9.70
Total Taxes and Fees	9.55%	$44.10

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Exhibit 11
Projected Age/Gender Distribution

Age	Male	Female	DC Age Factor
0-20	0.04%	0.04%	0.000
0-14	9.69%	9.16%	0.654
15	0.74%	0.72%	0.654
16	0.74%	0.66%	0.654
17	0.66%	0.66%	0.654
18	0.66%	0.72%	0.654
19	0.77%	0.68%	0.654
20	0.74%	0.62%	0.654
21	0.78%	0.64%	0.727
22	0.69%	0.68%	0.727
23	0.77%	0.76%	0.727
24	0.75%	0.75%	0.727
25	0.83%	0.73%	0.727
26	0.85%	0.85%	0.727
27	0.80%	0.83%	0.727
28	0.83%	0.81%	0.744
29	0.87%	0.90%	0.760
30	0.98%	0.85%	0.779
31	1.02%	0.94%	0.799
32	1.10%	0.85%	0.817
33	1.07%	0.90%	0.836
34	1.05%	0.99%	0.856
35	1.12%	0.95%	0.876
36	1.12%	0.89%	0.896
37	0.89%	0.81%	0.916
38	0.90%	0.79%	0.927
39	0.93%	0.81%	0.938
40	0.95%	0.77%	0.975
41	0.90%	0.80%	1.013
42	0.83%	0.79%	1.053
43	1.00%	0.84%	1.094
44	1.03%	0.86%	1.137
45	1.00%	0.86%	1.181
46	0.98%	0.84%	1.227
47	0.95%	0.86%	1.275
48	1.00%	0.74%	1.325
49	0.99%	0.72%	1.377
50	0.97%	0.82%	1.431
51	0.93%	0.86%	1.487
52	1.15%	0.82%	1.545
53	1.09%	0.90%	1.605
54	0.92%	0.75%	1.668
55	0.95%	0.71%	1.733
56	0.87%	0.69%	1.801
57	0.80%	0.61%	1.871
58	0.68%	0.54%	1.944
59	0.71%	0.56%	2.020
60	0.64%	0.53%	2.099
61	0.52%	0.42%	2.181
62	0.47%	0.39%	2.181
63	0.44%	0.35%	2.181
64	0.38%	0.30%	2.181
65+	0.66%	0.47%	2.181

Age Calibration Factor	1.047

Note:
Age Calibration Factor
computed as the weighted average of
HHS Age Factor by projected membership
distribution.

Weighted Average Age	42

Note:
This is the age that most closely
corresponds to the age calibration factor.

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Exhibit 12
Comparison of Key Pricing Factors to LY (2017) Pricing

Category	2017	2018	% Impact to Premium	Description
Base Experience PMPM*	$239.59	$266.93	6.6%	Using all SG experience (HMO/PPO) from IH to price DC
Pricing Trend (annual)	9.7%	11.1%	9.5%	Experience higher utilization and unit cost pressure
Morbidity	1.01	1.03	1.9%	Expecting market risk pool to deteriorate
Benefit	0.943	0.947	-0.7%	Leaner portfolio in 2018 compared to 2017
Demographic	1.001	1.000	0.0%	No material change
Area Factor	1.000	1.000	0.0%	No material change
Other	0.973	0.967	-0.9%	
Network Change	1.054	1.060	1.3%	Adj to normalize experience for manual pricing
Risk Adjustment	-$66.50	-$19.76	-11.3%	
Projected Claim Cost	**$322.32**	**$348.90**	**6.4%**	
% of Premium Items				
Admin	**9.2%**	**9.4%**	**1.3%**	decreasing market footprint leads to increasing admin costs PMPM
Profit	**6.0%**	**6.0%**	**0.7%**	
FIT	2.10%	2.10%	0.2%	No material change
AFIT	3.90%	3.90%	0.4%	No material change
Taxes & Fees	**7.0%**	**9.0%**	**3.1%**	
Commissions	3.4%	1.5%	-1.7%	Reducing commissions
Prem Tax	2.5%	3.3%	1.2%	
HIF	0.0%	3.2%	3.5%	Introducing HIF back in from 1 yr hiatus
Federal EUF	1.0%	1.0%	0.1%	
State EUF	0.0%	0.0%	0.0%	N/A
PCORI	0.04%	0.04%	0.0%	No material change
Total % of Prem	22.18%	24.43%		
Single Risk Pool Premium (Wksht 1)	**$414.19**	**$461.71**	**11.5%**	
SG Trend Factor	1.048	1.020	-2.7%	
Index Rate	$434.16	$470.89		
Age 21 Factor	0.727	0.727		
Avg 1.0 Premium	$315.63	$342.34		
Premium Mix	0.994	1.003	0.9%	
Avg Projection Period Premium	**$313.81**	**$343.31**	**9.4%**	

Footnotes

*Base Experience PMPM for 2017 is 2015 Claims experience used for pricing LY with 1 year of trend (9.7%) to bring the claim level to 2016

*Base Experience PMPM for 2018 is 2016 Claims experience

Unique Plan Design - Issuer Actuarial Value
Supporting Documentation and Justification

State: DC
Plan Year: 2018
HIOS Issuer ID: 73987
HIOS Product Ids: 73987DC004

HIOS Plan Ids: 73987DC0040057, 73987DC0040046, 73987DC0040056, 73987DC0040021, 73987DC0040029, 73987DC0040017

1) Justification for use of Issuer AV:
Per 156.135, the AV must be certified by member of the American Academy of Actuaries using generally accepted actuarial principles and methodologies. There are 3 types of certification:

(1) Option 1 - Certify that the plan was entered correctly and do not vary materially from standard options entered
(2) Option 2 - Certify that modified entries into calculator to reflect plan appropriately [156.135.(b).(2)]
(3) Option 3 - Used calculator for provisions that fit and make adjustment for plan design features that deviate outside of calculator [156.135.(b).(3)]

Aetna benefit plans were analyzed vs the AVC to determined when Option 2 vs Option 1 certification was necessary. Three underlying calculators were built to support population of the Specialist OV, ER, and Rx generic rows in the AVC. These all support Option 2 certifications. In addition, all Aetna plans were run with coinsurance entered on each row where applicable, and a .9999 factor is applied to the average coinsurance in row 11 for most plans. While not materially impacting the entered benefit value, this methodology prevents the OP facility/physician splitting methodology from being invoked which we do not believe is appropriate for our benefit plans. The output from this consistently applied process reflects our certified Actuarial Values.

2) Regulatory permitted alternate method used:

(3) Option 3 - Used calculator for provisions that fit and make adjustment for plan design features that deviate outside of calculator [156.135.(b).(3)]

3) Confirmation that only in-network cost sharing including multitier networks, was considered:
Confirmed. Only in-network cost sharing information was used.

4) Description of standardized plan population data used:
Detail of data used for each of the subcalculators is described below in items 5 & 6. All data was based on either the AVC continuance tables, or a national data set which is representative of the

SG population

5) If the method described in 156.135.(b).(2) was used, description of how the benefits were modified to fit the parameters of the AV calculator:
None

6) If the method described in 156.135.(b).(3) was used, description of the data and method used to develop the adjustments:

TIF (True individual family) Deductible

For plans with a TIF deductible, the average change in paid to allowed due to this feature was determined based on internal cost data and a SG appropriate distribution of single vs family members. That process produces an additive adjustment to the AV obtained via the methodology described above in support of 156.135.(b).(2) certifications.

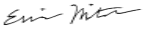
Certification Language:
The development of the actuarial value was determined in accordance with the ASOPs established by the ASB and with applicable laws and regulations.

This analysis was conducted by a member of the American Academy of Actuaries that meets the Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion in the United States promulgated by the American Academy of Actuaries, and has the education and experience necessary to perform the work.

The certifying actuary is an employee of Aetna.

This certification supports plans offered in the Small Group market.

Metal levels were appropriately assigned based on applicable law.

Actuary Signature: 
Actuary Printed name: Erica Mitchell, FSA MAAA
Date: 5/1/2017

Aetna Health Inc. (a PA corp.)
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Exhibit A
Product Portfolio & Projected Membership Distribution

HIOS Plan-ID	Network	Plan	Metallic Tier	Actuarial Value	Exchange Offering	Projected Membership Distribution
73987DC0040017	HMO	DC Gold HMO 70%	Gold	81.73%	Yes	25.34%
73987DC0040021	HMO	DC Gold HMO 500 90%	Gold	78.15%	Yes	39.89%
73987DC0040029	HMO	DC Silver HMO 3000 100% HSA E	Silver	68.89%	Yes	12.44%
73987DC0040046	HMO	DC Gold HMO 1600 100% HSA T	Gold	78.37%	Yes	5.30%
73987DC0040056	HMO	DC Bronze HMO 5000 80% HSA E	Bronze	61.71%	Yes	11.87%
73987DC0040057	HMO	DC Silver HMO 4500 80%	Silver	70.95%	Yes	5.17%

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Exhibit A-1
Rate Change by Plan

2017 HIOS Plan ID	2017 Plan Name	1Q2017 Premium Rate	2018 HIOS Plan ID	2018 Plan Name	1Q2018 Premium Rate	Rate Change
73987DC0040021	DC Gold HNOnly 500 90% T	$323.82	73987DC0040021	DC Gold HMO 500 90%	$352.25	8.8%
73987DC0040017	DC Gold HNOnly 70% T	$314.02	73987DC0040017	DC Gold HMO 70%	$342.82	9.2%
73987DC0040035	DC Silver HNOnly SJ 2500 100%	$255.79	73987DC0040029	DC Silver HMO 3000 100% HSA E	$281.96	10.2%
73987DC0040001	DC Bronze HNOnly 5600 100% HSA E	$201.69	73987DC0040056	DC Bronze HMO 5000 80% HSA E	$223.62	10.9%
73987DC0040034	DC Gold HNOnly SJ 1500 100%	$290.07	73987DC0040046	DC Gold HMO 1600 100% HSA T	$342.43	18.1%
73987DC0040029	DC Silver HNOnly 2700 100% HSA T	$249.43	73987DC0040029	DC Silver HMO 3000 100% HSA E	$281.96	13.0%
73987DC0040046	DC Gold HNOnly 1700 100% HSA T	$309.27	73987DC0040046	DC Gold HMO 1600 100% HSA T	$342.43	10.7%
73987DC0040050	DC Gold HNOnly 3500 100% Simple	$303.04	73987DC0040046	DC Gold HMO 1600 100% HSA T	$342.43	13.0%
73987DC0040051	DC Gold HNOnly 3500 100% Simple RE	$298.65	73987DC0040046	DC Gold HMO 1600 100% HSA T	$342.43	14.7%
73987DC0040047	DC Gold HNOnly 1700 100% HSA T RE	$304.23	73987DC0040046	DC Gold HMO 1600 100% HSA T	$342.43	12.6%
73987DC0040049	DC Bronze HNOnly 6450 100% Simple HSA E RE	$226.34	73987DC0040056	DC Bronze HMO 5000 80% HSA E	$223.62	-1.2%
73987DC0040053	DC Silver HNOnly 3500 90% HSA E RE	$237.55	73987DC0040056	DC Bronze HMO 5000 80% HSA E	$223.62	-5.9%
73987DC0040048	DC Bronze HNOnly 6450 100% Simple HSA E	$230.52	73987DC0040056	DC Bronze HMO 5000 80% HSA E	$223.62	-3.0%
73987DC0040055	DC Silver HNOnly 5350 100% Simple RE	$260.48	73987DC0040056	DC Bronze HMO 5000 80% HSA E	$223.62	-14.2%
73987DC0040036	DC Bronze HNOnly 5600 100% HSA E RE	$197.44	73987DC0040056	DC Bronze HMO 5000 80% HSA E	$223.62	13.3%
73987DC0040044	DC Silver HNOnly SJ 2500 100% RE	$251.71	73987DC0040029	DC Silver HMO 3000 100% HSA E	$281.96	12.0%
73987DC0040052	DC Silver HNOnly 3500 90% HSA E	$242.16	73987DC0040056	DC Bronze HMO 5000 80% HSA E	$223.62	-7.7%
73987DC0040040	DC Gold HNOnly SJ 1500 100% RE	$285.74	73987DC0040046	DC Gold HMO 1600 100% HSA T	$342.43	19.8%
73987DC0040054	DC Silver HNOnly 5350 100% Simple	$264.62	73987DC0040056	DC Bronze HMO 5000 80% HSA E	$223.62	-15.5%
73987DC0040041	DC Gold HNOnly 70% T RE	$308.52	73987DC0040017	DC Gold HMO 70%	$342.82	11.1%
73987DC0040042	DC Gold HNOnly 500 90% T RE	$318.32	73987DC0040021	DC Gold HMO 500 90%	$352.25	10.7%
73987DC0040045	DC Silver HNOnly 2700 100% HSA T RE	$244.64	73987DC0040029	DC Silver HMO 3000 100% HSA E	$281.96	15.3%

Aetna Health Inc.

HMO

Actuarial Value Screenshots

DC Gold HMO 1600 100% HSA T

Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$1,600.00
Coinsurance (%, Insurer's Cost Share)			100.00%
MOOP ($)			$3,575.00
MOOP if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			
Coinsurance (%, Insurer's Cost Share)			
MOOP ($)			
MOOP if Separate ($)			

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$0.00	☑	☑			☐	☐
All Inpatient Hospital Services (inc. MHSU)	☑	☐		$0.00	☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$15.00	☑	☑			☑	☐
Specialist Visit	☑	☐		$50.00	☑	☑			☑	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☐		$25.00	☑	☑			☑	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$0.00	☑	☑			☐	☐
Speech Therapy	☑	☐		$0.00	☑	☑			☐	☐
Occupational and Physical Therapy	☑	☐		$0.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☐		$0.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☐		$0.00	☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$0.00	☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$0.00	☑	☑			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑	100%		☑	☑			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☐		$10.00	☑	☑			☑	☐
Preferred Brand Drugs	☑	☐		$45.00	☑	☑			☑	☑
Non-Preferred Brand Drugs	☑	☐		$85.00	☑	☑			☑	☑
Specialty Drugs (i.e. high-cost)	☑	☑	70%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$300
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

Name: DC Gold HMO 1600 100% HSA T
Plan HIOS ID: 73987DC0040046
Issuer HIOS ID: 73987

Output

Calculate

Status/Error Messages:	
Actuarial Value:	79.37%
Metal Tier:	Gold
Additional Notes:	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Calculation Time:	0.0469 seconds

2018 AV Calculator

Option 3 Additive TIF adj	-1.00%
Final AV	78.37%

This product, DC Gold HMO 1600 100% HSA T, satisfies the HHS guidelines for a gold plan with an Actuarial Value of 78.37%

DC Silver HMO 3000 100% HSA E

Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$3,000.00
Coinsurance (%, Insurer's Cost Share)			100.00%
MOOP ($)			$6,500.00
MOOP if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			
Coinsurance (%, Insurer's Cost Share)			
MOOP ($)			
MOOP if Separate ($)			

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$500.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSU)	☑	☐		$0.00	☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$30.00	☑	☑			☑	☐
Specialist Visit	☑	☐		$75.00	☑	☑			☑	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☐		$25.00	☑	☑			☑	☐
Imaging (CT/PET Scans, MRIs)	☑	☐		$0.00	☑	☑			☐	☐
Speech Therapy	☑	☐		$75.00	☑	☑			☑	☐
Occupational and Physical Therapy	☑	☐		$75.00	☑	☑			☑	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☐		$0.00	☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☐		$0.00	☑	☑			☐	☐
Skilled Nursing Facility	☑	☐		$0.00	☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$0.00	☑	☑			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑	100%		☑	☑			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☐		$12.00	☑	☑			☑	☐
Preferred Brand Drugs	☑	☐		$55.00	☑	☑			☑	☑
Non-Preferred Brand Drugs	☑	☐		$95.00	☑	☑			☑	☑
Specialty Drugs (i.e. high-cost)	☑	☑	60%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$500
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

Name: DC Silver HMO 3000 100% HSA E
Plan HIOS ID: 73987DC0040029
Issuer HIOS ID: 73987

Output

Calculate

Status/Error Messages:	
Actuarial Value:	68.89%
Metal Tier:	Silver
Additional Notes:	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Calculation Time:	0.0469 seconds

2018 AV Calculator

This product, DC Silver HMO 3000 100% HSA E, satisfies the HHS guidelines for a silver plan with an Actuarial Value of 68.89%

DC Bronze HMO 5000 80% HSA E

Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Bronze

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,000.00
Coinsurance (%, Insurer's Cost Share)			80.00%
MOOP ($)			$6,550.00
MOOP if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			
Coinsurance (%, Insurer's Cost Share)			
MOOP ($)			
MOOP if Separate ($)			

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☑	80%		☑	☑			☐	☐
All Inpatient Hospital Services (inc. MHSU)	☑	☑	80%		☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$40.00	☑	☑			☑	☐
Specialist Visit	☑	☐		$100.00	☑	☑			☑	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☐		$25.00	☑	☑			☑	☐
Imaging (CT/PET Scans, MRIs)	☑	☑	80%		☑	☑			☐	☐
Speech Therapy	☑	☑	80%		☑	☑			☐	☐
Occupational and Physical Therapy	☑	☑	80%		☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑	80%		☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑	80%		☑	☑			☐	☐
Skilled Nursing Facility	☑	☑	80%		☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	80%		☑	☑			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑	80%		☑	☑			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☑	☐		$15.00	☑	☑			☑	☐
Preferred Brand Drugs	☑	☐		$65.00	☑	☑			☑	☑
Non-Preferred Brand Drugs	☑	☐		$100.00	☑	☑			☑	☑
Specialty Drugs (i.e. high-cost)	☑	☑	60%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$500
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

Name: DC Bronze HMO 5000 80% HSA E
Plan HIOS ID: 73987DC0040056
Issuer HIOS ID: 73987

Output

Calculate

Status/Error Messages:	
Actuarial Value:	61.71%
Metal Tier:	Bronze
Additional Notes:	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Calculation Time:	0.0312 seconds

2018 AV Calculator

This product, DC Bronze HMO 5000 80% HSA E, satisfies the HHS guidelines for a bronze plan with an Actuarial Value of 61.71%

DC Gold HMO 70%

Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)	$0.00	$0.00	
Coinsurance (%, Insurer's Cost Share)	70.00%	100.00%	
MOOP ($)	$6,000.00		
MOOP if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☐	☑	70%		☑	☑			☐	☐
All Inpatient Hospital Services (inc. MHSU)	☐	☑	70%		☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$25.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$65.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$25.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☐	☑	70%		☑	☑			☐	☐
Speech Therapy	☐	☐		$65.00	☑	☑			☐	☐
Occupational and Physical Therapy	☐	☐		$65.00	☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☐	☑	70%		☑	☑			☐	☐
X-rays and Diagnostic Imaging	☐	☑	70%		☑	☑			☐	☐
Skilled Nursing Facility	☐	☑	70%		☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☑	70%		☑	☑			☐	☐
Outpatient Surgery Physician/Surgical Services	☐	☑	70%		☑	☑			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$10.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$45.00	☑	☑			☐	☑
Non-Preferred Brand Drugs	☐	☐		$85.00	☑	☑			☐	☑
Specialty Drugs (i.e. high-cost)	☐	☑	70%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$300
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

Name: DC Gold HMO 70%
Plan HIOS ID: 73987DC0040017
Issuer HIOS ID: 73987

Output

Calculate

Status/Error Messages:	
Actuarial Value:	81.73%
Metal Tier:	Gold
Additional Notes:	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Calculation Time:	0.0273 seconds

2018 AV Calculator

This product, DC Gold HMO 70%, satisfies the HHS guidelines for a gold plan with an Actuarial Value of 81.73%

DC Gold HMO 500 90%

Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)	$500.00	$0.00	
Coinsurance (%, Insurer's Cost Share)	90.00%	100.00%	
MOOP ($)	$7,150.00		
MOOP if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$500.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSU)	☑	☑	90%		☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$25.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$65.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$25.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑	90%		☑	☑			☐	☐
Speech Therapy	☑	☐		$65.00	☑	☑			☑	☐
Occupational and Physical Therapy	☑	☐		$65.00	☑	☑			☑	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☐		$15.00	☑	☑			☑	☐
X-rays and Diagnostic Imaging	☑	☐		$65.00	☑	☑			☑	☐
Skilled Nursing Facility	☑	☑	90%		☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☐		$500.00	☑	☑			☑	☐
Outpatient Surgery Physician/Surgical Services	☑	☑	100%		☑	☑			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$10.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$45.00	☑	☑			☐	☑
Non-Preferred Brand Drugs	☐	☐		$85.00	☑	☑			☐	☑
Specialty Drugs (i.e. high-cost)	☐	☑	70%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$300
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

Name: DC Gold HMO 500 90%
Plan HIOS ID: 73987DC0040021
Issuer HIOS ID: 73987

Output

Calculate

Status/Error Messages:	
Actuarial Value:	78.15%
Metal Tier:	Gold
Additional Notes:	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Calculation Time:	0.0312 seconds

2018 AV Calculator

This product, DC Gold HMO 500 90% , satisfies the HHS guidelines for a gold plan with an Actuarial Value of 78.15%

DC Silver HMO 4500 80%

Actuarial Value Snapshot

The Actuarial Value Calculator (AV Calculator) is designed to give an estimate of network liability for a given plan design. This build of the AV Calculator uses data from a large national commercial database to build continuance tables by metal tier.

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☐
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount:		1st Tier Utilization:	
		2nd Tier Utilization:	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)	$4,500.00	$0.00	
Coinsurance (%, Insurer's Cost Share)	80.00%	100.00%	
MOOP ($)	$7,150.00		
MOOP if Separate ($)			

Tier 2 Plan Benefit Design	Medical	Drug	Combined

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate	Tier 1 Copay applies only after deductible?	Tier 2 Copay applies only after deductible?
Medical	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Emergency Room Services	☑	☐		$750.00	☑	☑			☑	☐
All Inpatient Hospital Services (inc. MHSU)	☑	☑	80%		☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00	☑	☑			☐	☐
Specialist Visit	☐	☐		$75.00	☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☐	☐		$25.00	☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑	80%		☑	☑			☐	☐
Speech Therapy	☑	☐		$75.00	☑	☑			☑	☐
Occupational and Physical Therapy	☑	☐		$75.00	☑	☑			☑	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑	80%		☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑	80%		☑	☑			☐	☐
Skilled Nursing Facility	☑	☑	80%		☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	80%		☑	☑			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑	80%		☑	☑			☐	☐
Drugs	☑ All	☑ All			☑ All	☑ All			☐ All	☐ All
Generics	☐	☐		$12.00	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$55.00	☑	☑			☐	☑
Non-Preferred Brand Drugs	☐	☐		$95.00	☑	☑			☐	☑
Specialty Drugs (i.e. high-cost)	☐	☑	60%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☑
Specialty Rx Coinsurance Maximum:	$500
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Plan Description:

Name: DC Silver HMO 4500 80%
Plan HIOS ID: 73987DC0040057
Issuer HIOS ID: 73987

Output

Calculate

Status/Error Messages:	
Actuarial Value:	70.95%
Metal Tier:	Silver
Additional Notes:	NOTE: Service-specific cost-sharing is applying for service(s) with fac/prof components, overriding outpatient inputs for those service(s).
Calculation Time:	0.0469 seconds

2018 AV Calculator

This product, DC Silver HMO 4500 80% , satisfies the HHS guidelines for a silver plan with an Actuarial Value of 70.95%

Aetna Health Inc. (a PA corp.)
HIOS ISSUER ID: 73987

Exhibit E-1
Calculation of Market Adjusted Index Rate

Projected Index Rate:	$421.67
Net Risk Adjustment:	1.060
Exchange User Fees:	1.014
Total Impact:	0.074
Market Adjusted Index Rate:	$452.91

Aetna Health Inc. (a PA corp.)
HIOS ISSUER ID: 73987

Exhibit 6
MLR Projection

			Formula
(a)	Premium (pmpm)	$461.71	
(b)	Medical Cost (pmpm)	$346.45	
(c)	Medical Benefit Ratio (MBR)	75.0%	= (c) / (b)
(d)	Quality Improvement Action (pmpm)	$2.65	= (a) x 0.57%
(e)	Taxes and Fees (pmpm)	$46.55	
(f)	Adjusted Premium (pmpm)	$415.16	=(a) - (e)
(g)	Adjusted Claims (pmpm)	$349.10	= (b) + (d)
	Medical Loss Ratio (MLR)	**84.1%**	=(g) / (f)

Notes:
ACA adjustments for QIA and taxes and fees are estimates based on historical experience and projected expenses.

Values reflect current actuarial projections and will differ from the final reported MLR.

This projection applies to the products included in this filing and is a standalone calculation for the 2018 calendar year. This projection differs from the MLR calculation specified by PPACA which includes three years of experience for all business in the MLR pool.

Aetna Health Inc. (a PA corp.)
HIOS ISSUER ID: 73987

Exhibit 7
Quarterly Trend Factors

Effective Quarter	Membership	Trend Factor	Index Rate
1Q 2018	60.0%	1.000	$413.44
2Q 2018	17.6%	1.026	$424.31
3Q 2018	10.4%	1.053	$435.46
4Q 2018	12.0%	1.081	$446.90
Total	100.0%	1.020	$421.67

Aetna Health Inc. (a PA corp.)
HIOS ISSUER ID: 73987

Exhibit 8
Trend Exhibit

Service Type	Unit Cost	Utilization	Total
Facility Inpatient	6.0%	2.4%	8.5%
Facility Outpatient	4.9%	6.4%	11.6%
Physician	1.8%	4.4%	6.2%
Capitation	0.0%	0.0%	0.0%
Medical	3.7%	5.2%	9.1%
Pharmacy	7.7%	4.0%	12.0%
Total (Med + Rx)	4.4%	5.0%	9.6%

Aetna Health Inc. (a PA corp.)
HIOS ISSUER ID: 73987

Exhibit 9

Sample Rate Calculation

The following steps outline the mathematical formula used to develop the member level rates for a sample small group.
The input assumptions and the census provided below are for illustrative purposes only.

Sample Small Group Information:

Effective Date: 1/1/2018
Rating Area: Rating Area 1
Plan: DC Gold HMO 500 90%

Group Census	Employee Age	Spouse Age	Child 1 Age	Child 2 Age	Child 3 Age
Employee 1	35	36	5	7	
Employee 2	56	52			
Employee 3	24	21			
Employee 4	52	49	19	17	16
Employee 5	65	65	25		
Employee 6	58	60	24		
Employee 7	56	51			
Employee 8	42	41			
Employee 9	33	34	5	6	7
Employee 10	25	28	2	1	

Age and Tobacco Factors	Age Factors				
	Employee	Spouse	Child 1	Child 2	Child 3
Employee 1	0.876	0.896	0.654	0.654	
Employee 2	1.801	1.545			
Employee 3	0.727	0.727			
Employee 4	1.545	1.377	0.654	0.654	0.654
Employee 5	2.181	2.181	0.727		
Employee 6	1.944	2.099	0.727		
Employee 7	1.801	1.487			
Employee 8	1.053	1.013			
Employee 9	0.836	0.856	0.654	0.654	0.654
Employee 10	0.727	0.744	0.654	0.654	

Calculation of Monthly Premium

Step 1: Multiply Market Base Rate x Rating Area Factor x Plan Factor x Effective Date Factor

Market Base Rate =	$554.02
x Rating Area Factor (Rating Area 1)	1.00
x Plan Factor	0.874558
x Effective Date Factor	1.00
Market Base Rate adjusted for Plan/Area/Effective Date =	$484.52

Step 2: Multiply Adjusted Market Base Rate in Step 1 by the Member level Age and Tobacco Factors:

Member Monthly Rates	Employee	Spouse	Child 1	Child 2	Child 3	Total
Employee 1	$424.44	$434.13	$316.88	$316.88		$1,492.33
Employee 2	$872.63	$748.59				$1,621.22
Employee 3	$352.25	$352.25				$704.50
Employee 4	$748.59	$667.19	$316.88	$316.88	$316.88	$2,366.42
Employee 5	$1,056.74	$1,056.74	$352.25			$2,465.73
Employee 6	$941.91	$1,017.01	$352.25			$2,311.17
Employee 7	$872.63	$720.49				$1,593.12
Employee 8	$510.20	$490.82				$1,001.02
Employee 9	$405.06	$414.75	$316.88	$316.88	$316.88	$1,770.45
Employee 10	$352.25	$360.48	$316.88	$316.88		$1,346.49
Group Total Monthly Premium:						**$16,672.45**

Note: Member level monthly rates are rounded to the nearest penny.

Aetna Health Inc. (a PA corp.)
HIOS ISSUER ID: 73987

Exhibit 10
Plan Mapping

2016 HIOS Plan ID	2016 Plan Name	2017 HIOS Plan ID	2017 Plan Name	2018 HIOS Plan ID	2018 Plan Name
73987DC0040001	DC Bronze HNOnly 5400 100% HSA Emb	73987DC0040001	DC Bronze HNOnly 5600 100% HSA E	73987DC0040056	DC Bronze HMO 5000 80% HSA E
73987DC0040005	DC Gold HNOnly 2000 70%	73987DC0040035	DC Silver HNOnly SJ 2500 100%	73987DC0040029	DC Silver HMO 3000 100% HSA E
73987DC0040017	DC Gold HNOnly 70%	73987DC0040017	DC Gold HNOnly 70% T	73987DC0040017	DC Gold HMO 70%
73987DC0040021	DC Gold HNOnly 500 90%	73987DC0040021	DC Gold HNOnly 500 90% T	73987DC0040021	DC Gold HMO 500 90%
73987DC0040025	DC Bronze HNOnly 5000 80% HSA Emb	73987DC0040001	DC Bronze HNOnly 5600 100% HSA E	73987DC0040056	DC Bronze HMO 5000 80% HSA E
73987DC0040029	DC Silver HNOnly 2500 90% HSA	73987DC0040029	DC Silver HNOnly 2700 100% HSA T	73987DC0040029	DC Silver HMO 3000 100% HSA E
73987DC0040034	DC Gold HNOnly SJ 1500 100%	73987DC0040034	DC Gold HNOnly SJ 1500 100%	73987DC0040046	DC Gold HMO 1600 100% HSA T
73987DC0040035	DC Silver HNOnly SJ 2500 100%	73987DC0040035	DC Silver HNOnly SJ 2500 100%	73987DC0040029	DC Silver HMO 3000 100% HSA E
73987DC0040036	DC Bronze HNOnly 5400 100% HSA Emb RE	73987DC0040036	DC Bronze HNOnly 5600 100% HSA E RE	73987DC0040056	DC Bronze HMO 5000 80% HSA E
73987DC0040037	DC Gold HNOnly 2000 70% RE	73987DC0040044	DC Silver HNOnly SJ 2500 100% RE	73987DC0040029	DC Silver HMO 3000 100% HSA E
73987DC0040040	DC Gold HNOnly SJ 1500 100% RE	73987DC0040040	DC Gold HNOnly SJ 1500 100% RE	73987DC0040046	DC Gold HMO 1600 100% HSA T
73987DC0040041	DC Gold HNOnly 70% RE	73987DC0040041	DC Gold HNOnly 70% T RE	73987DC0040017	DC Gold HMO 70%
73987DC0040042	DC Gold HNOnly 500 90% RE	73987DC0040042	DC Gold HNOnly 500 90% T RE	73987DC0040021	DC Gold HMO 500 90%
73987DC0040043	DC Bronze HNOnly 5000 80% HSA Emb RE	73987DC0040036	DC Bronze HNOnly 5600 100% HSA E RE	73987DC0040056	DC Bronze HMO 5000 80% HSA E
73987DC0040044	DC Silver HNOnly SJ 2500 100% RE	73987DC0040044	DC Silver HNOnly SJ 2500 100% RE	73987DC0040029	DC Silver HMO 3000 100% HSA E
73987DC0040045	DC Silver HNOnly 2500 90% HSA RE	73987DC0040045	DC Silver HNOnly 2700 100% HSA T RE	73987DC0040029	DC Silver HMO 3000 100% HSA E
73987DC0040046	DC Gold HNOnly 1700 100% HSA	73987DC0040046	DC Gold HNOnly 1700 100% HSA T	73987DC0040046	DC Gold HMO 1600 100% HSA T
73987DC0040047	DC Gold HNOnly 1700 100% HSA RE	73987DC0040047	DC Gold HNOnly 1700 100% HSA T RE	73987DC0040046	DC Gold HMO 1600 100% HSA T
		73987DC0040048	DC Bronze HNOnly 6450 100% Simple HSA E	73987DC0040056	DC Bronze HMO 5000 80% HSA E
		73987DC0040049	DC Bronze HNOnly 6450 100% Simple HSA E RE	73987DC0040056	DC Bronze HMO 5000 80% HSA E
		73987DC0040050	DC Gold HNOnly 3500 100% Simple	73987DC0040046	DC Gold HMO 1600 100% HSA T
		73987DC0040051	DC Gold HNOnly 3500 100% Simple RE	73987DC0040046	DC Gold HMO 1600 100% HSA T
		73987DC0040052	DC Silver HNOnly 3500 90% HSA E	73987DC0040056	DC Bronze HMO 5000 80% HSA E
		73987DC0040053	DC Silver HNOnly 3500 90% HSA E RE	73987DC0040056	DC Bronze HMO 5000 80% HSA E
		73987DC0040054	DC Silver HNOnly 5350 100% Simple	73987DC0040056	DC Bronze HMO 5000 80% HSA E
		73987DC0040055	DC Silver HNOnly 5350 100% Simple RE	73987DC0040056	DC Bronze HMO 5000 80% HSA E
				73987DC0040057	DC Silver HMO 4500 80%

RATE FILING REQUIREMENTS INDIVIDUAL AND SMALL GROUP
PLANS SOLD ON DC HEALTH LINK
CHECK-LIST

INSTRUCTIONS: Include all required elements in the table below with the filed rates. The data elements listed in the Actuarial Memorandum should be consistent with the cover letter, if applicable.

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
1	Purpose of Filing	State the purpose of the filing. Identify the applicable law. List the proposed changes to the base rates and rating factors, and provide a general summary.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 1
2	Form Numbers	Form numbers should be listed in the actuarial memorandum.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 12
3	HIOS Product ID	The HIOS product ID should be listed in the actuarial memorandum.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 1
4	Effective Date	The requested effective date of the rate change. For filings effective 1/1/2018 and later, follow filing due date requirements.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 1
5	Market	Indicate whether the products are sold in the individual or small employer group market.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 1
6	Status of Forms	Indicate whether the forms are open to new sales, closed, or a mixture of both, and whether the forms are grandfathered, non- grandfathered, or a mixture of both.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 1
7	Benefits/Metal level(s)	Include a basic description of the benefits of the forms referenced in the filing and the metal level of each plan design.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 1-2
Number	**Data Element**	**Requirement Description**	**Individual and Small Group**	
			Has the Data Element Been Included?	**Location of the Data Element**
7.1	AV Value	Provide the actuarial value of each plan design using the AV calculator developed and made available by HHS.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 1-2, Exhibit A
8	Average Rate Increase Requested	The weighted average rate increase being requested, incremental and year-over-year renewal. The weights should be based on premium volume. **In the small group market, please also provide weighted average rate increase requested for 2017Q1 over 2016Q1; etc.**	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 2
9	Maximum Rate Increase Requested	The maximum rate increase that could be applied to a policyholder based on changes to the base rate and rating factors, incremental and year-over-year renewal. (Does not include changes in the demographics of the covered members.)	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 2
10	Minimum Rate Increase Requested	The minimum rate increase that could be applied to a policyholder based on changes to the base rate and rating factors, incremental and year-over-year renewal. (Does not include changes in the demographics of the covered members.)	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 2
11	Absolute Maximum Premium Increase	The absolute maximum year-over-year renewal rate increase that could be applied to a policyholder, including demographic changes such as aging.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 2
12	Average Renewal Rate Increase for a Year	Calculate the average renewal rate increase, weighted by written premium, for renewals in the year ending with the effective period of the rate filing. The calculation must be performed for each HIOS product ID.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 2

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
13	Rate Change History	Rate change history of the forms referenced in the filing. If nationwide experience is used in developing the rates, provide separately the rate history for District of Columbia and the nationwide average rate history.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 2-3
14	Exposure	Current number of policies, certificates and covered lives.		DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 3
15	Member Months	Number of members in force during each month of the base experience period used in the rate development and in each of the two preceding twelve-month periods.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 3
16	Past Experience	Provide monthly earned premium and incurred claims for the base experience period used in the rate development and each of the two preceding twelve-month periods.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 3, 11
17	Index Rate	Provide the index rate.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 3
17.1	Rate Development	Show base experience used to develop rates and all adjustments and assumptions applied to arrive at the requested rates. For less than fully credible blocks, disclose the source of the base experience data used in the rate development and discuss the appropriateness of the data for pricing the policies in the filing.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 3-5
18	Credibility Assumption	If the experience of the policies included in the filing is not fully credible, state and provide support for the credibility formula used in the rate development.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 5
19	Trend Assumption	Show trend assumptions by major types of service as defined by HHS in the Part I Preliminary Justification template, separately by unit cost, utilization, and in total. Provide the development of the trend assumptions.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 5-6
20	Cost-Sharing Changes	Disclose any changes in cost sharing for the plans between the base experience period for rating and the requested effective date. Show how the experience has been adjusted for cost- sharing changes in the rate development. Provide support for the estimated cost impact of the cost-sharing changes.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 6
21	Benefit Changes	Disclose any changes in covered benefits for the plans between the base experience period for rating and the requested effective date. Show how the experience has been adjusted for changes in covered benefits in the rate development. Provide support for the estimated cost impact of the benefit changes.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 6, Exhibit E-2

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
22	Plan Relativities	For rate change filings, if the rate change is not uniform for all plan designs, provide support for all requested rate changes by plan design. Disclose the minimum, maximum, and average impact of the changes on policyholders. For initial filings, provide the derivation of any new plan factors.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 6, Exhibit E-2
23	Rating Factors	Provide the age and other rating factors used. Disclose any changes to rating factors, and the minimum, maximum, and average impact on policyholders. Provide support for any changes.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 6-7, Exhibit 3, Exhibit 7, Exhibit 11
23.1	Wellness Programs	Describe any wellness programs (as defined in section 2705(j) of the PHS Act) included in this filing.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 7
24	Distribution of Rate Increases	Anticipated distribution of rate increases due to changes in base rates, plan relativities, and rating factors. This need not include changes in demographics of the individual or group.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 7, Exhibit A-1
25	Claim Reserve Needs	Provide the claims for the base experience period separately for paid claims, and estimated incurred claims (including claim reserve). Indicate the incurred period used for the base period. Indicate the paid-through date of the paid claims, and provide a basic description of the reserving methodology for claims reserves and contract reserves, if any. Provide margins used, if any.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 7
26	Administrative Costs of Programs that Improve Health Care Quality	Show the amount of administrative costs included with claims in the numerator of the MLR calculation . Show that the amount is consistent with the most recently filed Supplemental Health Care Exhibit or provide support for the difference.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 7
Number	**Data Element**	**Requirement Description**	**Individual/and Small Group**	
			Has the Data Element Been Included?	**Location of the Data Element**
27	Taxes and Licensing or Regulatory Fees	Show the amount of taxes, licenses, and fees subtracted from premium in the denominator of your medical loss ratio calculation(c). Show that the amount is consistent with the most recently filed Supplemental Health Care Exhibit or provide support for the difference.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 7, Exhibit 6
28	Medical Loss Ratio (MLR)	Demonstrate that the projected loss ratio, including the requested rate change, meets the minimum MLR. Show the premium, claims, and adjustments separately with the development of the projected premium and projected claims (if not provided in the rate development section). If the loss ratio falls below the minimum for the subset of policy forms in the filing, show that when combined with all other policy forms in the market segment in District of Columbia, the loss ratio meets the minimum.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 8, Exhibit 6

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
29	Risk Adjustment	Provide rate information relating to the Risk Adjustment program. Information should include assumed Risk Adjustment user fees, Risk Adjustment PMPM excluding user fees and assumed distribution of enrollment by risk score, plan, and geographical area. Provide support for the assumptions, including any demographic changes. Provide information/study on the development of risk scores and Risk Adjustment PMPM. Provide previous year-end estimated risk adjustment payable or receivable amount and quantitative support for the amount.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 8
30	Past and Prospective Loss Experience Within and Outside the State	Indicate whether loss experience within or outside the state was used in the development of proposed rates. Provide an explanation for using loss experience within or outside the state.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 8
31	A Reasonable Margin for Reserve Needs	Show the assumed Margin for Reserve Needs used in the development of proposed rates. Margin for Reserve Needs includes factors that reflect assumed contributions to the company's surplus or the assumed profit margin. Demonstrate how this assumption was derived, how the assumption has changed from prior filings, and provide support for changes. If the assumption for Qualified Health Plans exceeds 3% as assumed in the risk corridor formula, justify the excess in light of the company's surplus position.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 8-9, Exhibit 5
Number	**Data Element**	**Requirement Description**	**Individual and Small Group**	
			Has the Data Element Been Included?	**Location of the Data Element**
32	Past and Prospective Expenses	Indicate the expense assumptions used in the development of proposed rates. Demonstrate how this assumption was derived. Show how this assumption has changed from prior filings, and provide support for any change. Provide the assumed administrative costs in the following categories: • Salaries, wages, employment taxes, and other employee benefits • Commissions • Taxes, licenses, and other regulatory fees • Cost containment programs / quality improvement activities • All other administrative expenses • Total	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 8-9
33	Any Other Relevant Factors Within and Outside the State	Show any other relevant factors that have been considered in the development of the proposed rates. Demonstrate how any related assumptions were derived. Show how these assumptions have changed from prior filings, and provide support for any change.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 9
34	Other	Any other information needed to support the requested rates or to comply with Actuarial Standard of Practice No. 8.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 9

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
35	Actuarial Certification	Signed and dated certification by a qualified actuary that the anticipated loss ratio meets the minimum requirement, the rates are reasonable in relation to benefits, the filing complies with the laws and regulations of the District of Columbia and all applicable Actuarial Standards of Practice, including ASOP No. 8, and that the rates are not unfairly discriminatory.	Yes	DC Small Group Actuarial Memorandum - AHI 1Q18.doc - pg 9-10
36	Part I Preliminary Justification (Grandfathered Plan Filings)	Rate Summary Worksheet --- Provide this document with all Grandfathered plan filings. **Provide in Excel and PDF format.**	N/A	N/A
36.1	Unified Rate Review Template (Non-Grandfathered Filings)	Unified Rate Review Template as specified in the proposed Federal Rate Review regulation. Provide this document with all Non-Grandfathered plan filings. **Provide in Excel and PDF format.**	Yes	Supporting Documentaion
37	Part II Preliminary Justification	Written description justifying the rate increase as specified by 45 CFR § 154.215(f). Provide for *all* individual and small employer group filings (whether or not they are "subject to review" as defined by HHS).	Yes	Supporting Documentation
38	DISB Actuarial Memorandum Dataset	Summarizes data elements contained in Actuarial Memorandum. Provide this document with all Non- Grandfathered plan filings. **Provide in Excel format only**.	Yes	Supporting Documentation
39	District of Columbia Plain Language Summary	Similar to the Part II Preliminary Justification, this is a written description of the rate increase as specified by 45 CFR § 154.215, but as a simple and brief narrative describing the data and assumptions that were used to develop the proposed rates. Provide this document for all individual and small employer group filings.	Yes	Supporting Documentation
40	Summary of Components for Requested Rate Change	DISB will require that issuers provide a chart listing a) any and all components of requested rate changes from the prior year; b) a quick summary/explanation of the change; and c) the actual percentage impact of the change for each component, such that the total for all components listed equals the total percentage change requested for the plan year.	Yes	Supporting Documentation

Number	Data Element	Requirement Description	Individual and Small Group	
			Has the Data Element Been Included?	Location of the Data Element
41	CCIIO Risk Adjustment Transfer Elements Extract (RATE 'E')	Received directly from CCIIO; this report should be completed and submitted by the set deadline for QHP submissions, or by **April 30th** of the current year, whichever is first.	Yes	Supporting Documentation
42	Additional Requirements for Stand-Alone Dental Plan Filings	Provide the following for stand-alone dental plan filings: • Identification of the level of coverage (i.e. low or high), including the actuarial value of the plan determined in accordance with the proposed rule; • Certification of the level of coverage by a member of the American Academy of Actuaries using generally accepted actuarial principles; and • Demonstration that the plan has a reasonable annual limitation on cost-sharing.	N/A	N/A

CERTIFYING SIGNATURE

The undersigned representative of the organization submitting this rate filing attests that all items contained in the above checklist have been included in the filing to the best of the company's ability.

Diane S. Anderson

(Print Name)

Diane S. Andersen

(Signature)